

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barrelville, RFD Mt. Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JULIA</u> <u>E.</u> <u>ABUCEVICZ</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 24, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>3/20/1882</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Wilno, Russia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. R.E. Meager, Mt. Savage, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Cholecystitis</u>	<u>1 year</u>	
Antecedent cause(s) (b) <u>Gall Stones</u>	<u>1 year</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Bruise Admissions between Gall Bladder and Large Intestine</u>	<u>1 year or more</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1946, to 3/24, 1951, that I last saw the deceased alive on 3/24, 1951, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William E. Mosely M.D. Mt. Savage Md. 3/24-1951

23. BURIAL, CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial 3/29/1951 Methodist Cemetery Mt. Savage, Md.

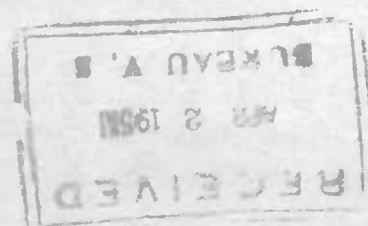
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

March 29, 1951 Wm. H. Kight, Cumberland, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 1

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Little Orleans (rural)</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>on his farm.</b>		STREET ADDRESS <b>445 Pennsylvania Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>Wilbur Summers Aronhalt</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>10</b> (Year) <b>1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 23-1885</b>
9. AGE last birthday <b>65</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel W. Aronhalt</b>		14. MOTHER'S MAIDEN NAME <b>Mary Susan Hanlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY No. <b>705-07-6674</b>	
17. INFORMANT AND ADDRESS <b>Grover Aronhalt (son) Ia Vale, Md.</b>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Acure cardiac failure due to</b>		<b>at once</b>
Antecedent cause(s) (b) <b>Myocardial degeneration</b>		<b>?</b>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md.

March 12-1951

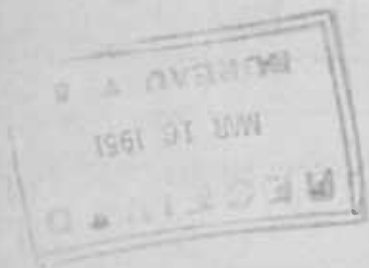
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/13/1951</b>	<b>Hill Crest Burial Park</b>	<b>Cumberland, Md.</b>

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>March 13, 1951</b>	<b>Dr. Sue C. Linewan</b>	<b>William H. Kight</b>	<b>Cumberland, Md.</b>

541506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02102

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH- COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>National</b>		LENGTH OF STAY (In this place) <b>10 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>National</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) <b>Blanche</b>		(Middle) <b>C</b>		(Last) <b>Atkinson</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, <del>SEPARATED</del> (Specify)		8. DATE OF BIRTH <b>Mar 10, 1899</b>	
						9. AGE last birthday <b>57</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Atkinson</b>				14. MOTHER'S MAIDEN NAME <b>Clara Brown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. (If yes, give war or dates of service)		17. INFORMANT <b>Leslie Brode</b>		<b>Frostburg, Md.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

420.1 Immediate cause (a) **Coronary occlusion**

93d Antecedent cause(s) (b) **Chronic Hypertensive Heart disease**

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **July**, 19**48**, to **6 March**, 19**51**, that I last saw the deceased  
alive on **6 March**, 19**51**, and that death occurred at **9 45** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION RE <b>Burial</b> (Specify)	DATE THEREOF <b>Mar 8, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	LOCATION (City, town, or county) <b>Frostburg</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG <b>3/8/51</b>	REGISTRAR'S SIGNATURE <b>Jannette McNeal</b>	24. FUNERAL DIRECTOR <b>M. Eichhorn</b>	ADDRESS <b>Lonaconing, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF ATTORNEY GENERAL

RECEIVED  
MAR 16 1951  
BUREAU A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02103

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frankfort</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frankfort</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>145 Ormand St.</u>		STREET ADDRESS (If rural, give location) <u>145 Ormand St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth</u> (Middle) <u>Ellen</u> (Last) <u>Baker</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-22-1872</u>
9. AGE last birthday <u>79</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Hampshire Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Anna Baker</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Emaciation - Toxemia - Metastatic Carcinoma

INTERVAL BETWEEN ONSET AND DEATH

3 1/2 yrs. - 3 mo.

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Pathological fracture both lower humeri -8 mo.(c) Carcinoma R breast -3 1/2 yrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertension?

19a. DATE OF OPERATION <u>1977</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma - R breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/21, 1979, to 3/4, 1951, that I last saw the deceased alive on 2/24, 1951, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-7-1951</u>	<u>Johns Hopkins Cem.</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-6-51</u>	<u>Mr. Harry H. Roe</u>	<u>Jacob Haffer</u>	<u>Frankfort, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 8 1961  
BUREAU OF

Within corporate limits.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02104

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

<b>1. PLACE OF DEATH:</b> COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cumberland</u> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>411 N. Centre St.</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> STREET ADDRESS (If rural, give location) <u>411 N. Centre St.</u>																	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Violet Anna Margaret</u> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> <u>Mar. 7,</u> 19 <u>51</u> (Month) (Day) (Year)		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWER, DIVORCED.</b> <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>11-12-1903</u> 47 yrs. (Specify)		<b>9. AGE last birthday</b> If under 1 year Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cumberland, Md.</u>		<b>12. CITIZEN OR WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Frank J. Forbeck</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucinda Stott</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)						<b>16. SOCIAL SECURITY No.</b> <u>214-28-6316</u>						<b>17. INFORMANT AND ADDRESS</b> <u>Alex Barron</u> <u>Cumberland, Md.</u>									
<b>18. MEDICAL CERTIFICATION</b>																					
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> 174x Immediate cause (a) <u>Pneumonia</u> 48b Antecedent cause(s) (b) <u>Complication of return to metastasis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)																INTERVAL BETWEEN ONSET AND DEATH					
<b>11. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.																					
<b>19a. DATE OF OPERATION</b> <u>4/26/1950</u>						<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Complication of return to metastasis</u>						<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
<b>21. ACCIDENT SUICIDE HOMICIDE</b> (Specify)						<b>PLACE (Home, farm, factory, street, OF office bldg., etc.)</b> (CITY OR TOWN) (COUNTY) (STATE)						<b>INJURY</b>									
<b>TIME (Month) (Day) (Year) (Hour) OF INJURY</b>						<b>INJURY OCCURRED</b> While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>						<b>HOW DID INJURY OCCUR?</b>									
<b>22. I hereby certify that I attended the deceased from....., 19....., to 3/7, 1951, that I last saw the deceased alive on 3/7, 1951, and that death occurred at P m., from the causes and on the date stated above.</b> SIGNATURE <u>John R. Rozman M.D.</u> ADDRESS <u>Cumberland</u> DATE SIGNED <u>3/9/51</u> (Degree or title)																					
<b>23. BURIAL, CREMATION REMOVAL (Specify)</b>						<b>DATE THEREOF</b> <u>3/10/51</u>						<b>NAME OF CEMETERY OR CREMATORY</b> <u>S. S. Peter &amp; Paul</u>						<b>LOCATION (City, town, or county) (State)</b> <u>Cumberland, Md.</u>			
<b>DATE REC'D BY LOCAL REG.</b> <u>March 9, 1951</u>						<b>REGISTRAR'S SIGNATURE</b> <u>Walter R. Smith M.D.</u>						<b>24. FUNERAL DIRECTOR</b> <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>									

VS. A15

RECEIVED  
MAR 19 1951  
R. H. HAY A. N.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02105

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS (If rural, give location) <u>229 Union Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Rose</u> (Middle) (Last) <u>Bartz</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>11</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 4 1892</u>
9. AGE last birthday <u>58</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>John Kroll</u>	14. MOTHER'S MAIDEN NAME <u>Barbara Reibig</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Gladys Bartz, Cumberland, Md.</u>	18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

9 mos

3 yrs

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24, 1950, to Mar 11, 1951, that I last saw the deceasedalive on Mar 9, 1951, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 13, 1951 Walter K. Bantz, M.D.William H. Kight Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

157  
MAR 20 1951  
BUREAU

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02106

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH - COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany County Infirmary</u>		STREET ADDRESS (If rural, give location) <u>Rt. #3 Bedford Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Margaret</u> (Middle) <u>Elizabeth</u> (Last) <u>Beane</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3-19-51</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/5/70</u>
9. AGE last birthday <u>80</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
13. FATHER'S NAME <u>John McCormack</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Zink</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Chas. Bosley, Cumberland, Md.</u>	
16. SOCIAL SECURITY No. <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Myocardial failure</u>		<u>1 wk</u>
(b) Antecedent cause(s) <u>Coronary sclerosis</u>		<u>5 yrs</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 26, 1951, to Mar. 19, 1951, that I last saw the deceased alive on Mar. 16, 1951, and that death occurred at 8:53 p.m., from the causes and on the date stated above.

SIGNATURE Arthur F. Jones M.D. (Degree or title) ADDRESS 110 S. Centre St. DATE SIGNED Mar. 20, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/22/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 22, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Panty, M.D.</u>	24. FUNERAL DIRECTOR ADDRESS <u>William H. Kight, Cumberland, Md.</u>	



# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 5

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Amesville, Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lonaconing</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Intelle Celanese Corp. of Am.</u>		STREET ADDRESS <u>Jackson St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert Anderson Beeman</u>		4. DATE OF DEATH <u>March 21</u> 19 <u>51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 6-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer in dye Dept. Celanese Corp. of Am.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>49</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Beeman</u>		14. MOTHER'S MAIDEN NAME <u>Janet Beeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-07-2745</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Jane Beeman</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a) <u>Coronary thrombosis with myocardial</u>		
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>infarction.</u>		
(c) <u>Died suddenly</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md.March 21-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Park Hill Cemetery</u>	LOCATION (City, town, or county) <u>Lonaconing, Md.</u>	(State)
DATE REC'D BY LOCAL REGISTRY <u>March 23, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>M. Eichhorn</u>	ADDRESS <u>Lonaconing, Md.</u>	

970466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02108

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>PENNSYLVANIA</b> COUNTY <b>BEDFORD</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>HYNDMAN</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS <b>SHELLSBURG STREET</b>	
3. NAME OF DECEASED (Type or Print) <b>GOLDIE</b> (First) <b>G.</b> (Middle) <b>BINGMAN</b> (Last)		4. DATE OF DEATH <b>MARCH 30, 1951</b> (Month) (Day) (Year)	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 7, 1917</b> 34 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
13. FATHER'S NAME <b>CHARLES KIRCHIMER</b>		14. MOTHER'S MAIDEN NAME <b>PEARL MINNICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

## Immediate cause

(a)

*Carcinoma Sigmoid Colon*

INTERVAL BETWEEN ONSET AND DEATH

*1 year*

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

*Feb 1950*

## 19b. MAJOR FINDINGS OF OPERATION

*Carcinoma Sigmoid Colon*

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan*, 19*50*, to *Mar 30*, 19*51*, that I last saw the deceasedalive on *Mar 30*, 19*51*, and that death occurred at *1:50* A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*3-30-51*

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

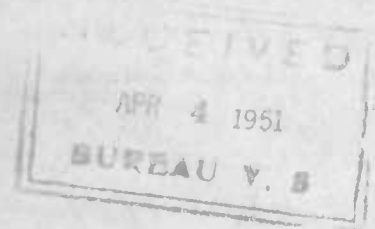
ADDRESS

*March 31, 1951**Walter L. Sandy, M.D.**Harvey S. Leigler**Hyndman*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02109

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location) <u>R.F.D. #1, Labale</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Ann</u> (Last) <u>Bradley</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 4, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year Months. Days Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Barton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Marbury</u>		14. MOTHER'S MAIDEN NAME <u>Jane Ann Emerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Harry Malcolm, Labale, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>uremia</u>			<u>2 weeks</u>
Antecedent cause(s) (b) <u>arteriosclerosis</u>			<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>fractured hip</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>Accident</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>home</u>	(CITY OR TOWN) <u>La Vale</u> (COUNTY) <u>Allegany</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2 21 4 P</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>slopped and fell</u>

22. I hereby certify that I attended the deceased from 2-21, 1951, to 3-16, 1951, that I last saw the deceased alive on 3-16, 1951, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>March 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	LOCATION (City, town, or county) <u>Roscoe, Maryland</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>March 19, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Panty, M.D.</u>	24. FUNERAL DIRECTOR <u>Edworth S. Boal, Westport, Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02110

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Alliegany</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>227 Springdale St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Mineral</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wiley Ford</u> TOWN <u>Cumberland, Md.</u> STREET ADDRESS <u>Wiley Ford, W.Va.</u>	
3. NAME OF DECEASED (Type or Print) <u>Laura A. Branson</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>10/26/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
13. FATHER'S NAME <u>Phillip Abe</u>		14. MOTHER'S MAIDEN NAME <u>Anna Largent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Elmer P. Branson Wiley Ford, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease

93d

(c)

INTERVAL BETWEEN ONSET AND DEATH  
Sudden4 yrsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar. 15, 1951, to Mar 22, 1951, that I last saw the deceasedalive on Feb. 15, 1951, and that death occurred at Mar. 22, 1951, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Elmer P. Branson M.D. Cumberland 3/23/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>3/26/51</u>	<u>Abe Cemetery</u>	<u>Short Gap W.Va.</u>

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS.
<u>March 23, 1951</u>	<u>Walter R. Brant, M.D.</u>	<u>James F. Scarpelli Cumberland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Within corporate limits

02111

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH-COUNTY <b>Allegheny</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE <b>Penna.</b> COUNTY <b>Bedford</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Cumberland,</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Bedford, Penna.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Memorial Hosp.</b>		STREET ADDRESS (If rural, give location) <b>Rt. # 1</b>	
3. NAME OF DECEASED (First) <b>ALBERT</b> (Middle) <b>B.</b> (Last) <b>BRITT</b>		4. DATE OF DEATH (Month) <b>Mar.</b> (Day) <b>26,</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Apr. 14, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Howard Johnson Rest.</b>	9. AGE last birthday <b>45</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Albert Britt</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Evans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>209-10-7571</b>	
17. INFORMANT AND ADDRESS <b>Memorial Hosp.</b>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause (a) <b>Uremia</b>	
Antecedent cause(s) (b) <b>nephritis, chronic</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Decadent ulcer active &amp; perforation into pancreas and recurrent pharyngitis</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>Jan. 13, 1951</b>	
19b. MAJOR FINDINGS OF OPERATION <b>(2) above - Gastric resection</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b> PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b> (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b> INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan. 8, 1951**, to **March 26, 1951**, that I last saw the deceased alive on **March 26, 1951**, and that death occurred at **5:26 a.m.**, from the causes and on the date stated above.

SIGNATURE **Robert M. Sawyer Jr.** (Degree or title) **M.D.** ADDRESS **Cumberland Md** DATE SIGNED **March 26, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>3/28/51</b>	NAME OF CEMETERY OR CREMATORY <b>Bedford Cem.</b>	LOCATION (City, town, or county) (State) <b>Bedford, Penna.</b>
DATE REC'D BY LOCAL REG. <b>March 26, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Hantz, M.D.</b>	24. FUNERAL DIRECTOR ADDRESS <b>H. Wayne George Cumberland, Md.</b>	

754679

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED  
JUN 4 1952  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

02112

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12:00, 1951, to 1:00, 1951, that I last saw the deceased

alive on 12:00, 1951, and that death occurred at 5:55 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

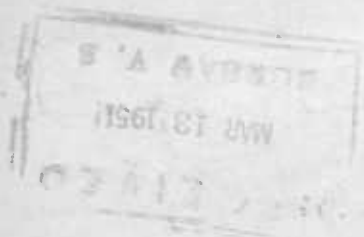
02113

Reg. Dist. No. 4

VS. A15 MARGIN RESERVED FOR BINDING PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural, give location) <u>306 Magruder Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edmonia</u> (Middle) (Last) <u>Bullett</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>6</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Mar 23 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Paw Paw, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Bullett</u>		14. MOTHER'S MAIDEN NAME <u>Leah Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Homer Bullett, Washington, Pa.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>2nd and 3rd degree burns of abdomen and thighs</u>			<u>5 days</u>
(b) <u>Circulatory - vascular - renal disease</u>			<u>5 years</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>Accident</u>		PLACE (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	
SUICIDE		HOMICIDE	
TIME (Month) (Day) (Year) (Hour) <u>Jan. 12, 1951</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> <u>How did injury occur?</u> <u>Burn caught fire from cigarette</u>	
22. I hereby certify that I attended the deceased from <u>January 5, 1951</u> to <u>March 6, 1951</u> , that I last saw the deceased alive on <u>March 6, 1951</u> , and that death occurred at <u>10 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. Johnson</u>		ADDRESS <u>W. H. Cumberland Md. 3-7-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar 9 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Camp Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Paw Paw, W. Va., (Md.)</u>	
DATE REC'D BY LOCAL REG. <u>March 8, 1951</u>		24. FUNERAL DIRECTOR <u>William H. Kight</u> ADDRESS <u>Cumberland, Md.</u>	

Dr. Johnson



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

02114

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>J</u>	(Last) <u>Buskirk</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 1, 1875</u>
9. AGE last birthday <u>75</u> yrs.		4. DATE OF DEATH <u>March 2</u>	(Month) <u>19</u> (Day) <u>51</u> (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Buskirk</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Frank Buskirk</u>		<u>Wodland, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Uremia

INTERVAL BETWEEN ONSET AND DEATH

2 days

## Antecedent cause(s)

(b)

Chronic glomerulonephritisyears

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Bronchial Asthma Chronic Heart Diseaseyears

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to 2 March, 1951, that I last saw the deceasedalive on 2 March, 1951, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

650216

RECEIVED  
MAR 16 1961  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02115

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>LONACONING</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL,</b>		STREET ADDRESS (If rural, give location) <b>80 EAST MAIN STREET</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>ELLA</b>	(Middle) <b>J.</b>	(Last) <b>CAMPBELL</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 21, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE last birthday <b>68</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>LONACONING, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH JONES</b>		14. MOTHER'S MAIDEN NAME <b>JEANETTE FATKIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) **Congestive Heart Failure**

## INTERVAL BETWEEN ONSET AND DEATH

**3 weeks**

## Antecedent cause(s)

(b) **arteriosclerotic Heart Disease**

(c) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **FEB. 23, 1951** to **3 mo., 1951**, that I last saw the deceasedalive on **3 mo., 1951**, and that death occurred at **9:45 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Dr. Alfred Van Ormer****Cumberland, Md.****3 mo. 51**

23. BURIAL, CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>March 5, 1951</b>	<b>Laurel Hill Cemetery</b>	<b>Md.</b>	<b>Md.</b>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>March 5, 1951</b>	<b>Winters R. Lang, M.D.</b>	<b>M. Eichhorn</b>	<b>Lonaconing, Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAR 13 1951  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02116

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS <u>New Row</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Joseph Nicholas Carter</u>		<u>3 5 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>Married</u> (Specify)	8. DATE OF BIRTH <u>12-15-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dye Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	9. AGE last birthday <u>58 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Ridgely, W. Va</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>Owen Carter</u>		14. MOTHER'S MAIDEN NAME <u>Clara Criswell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date service) <u>Yes World #1</u>		16. SOCIAL SECURITY NO. <u>214-07-0620</u>	
17. INFORMANT AND ADDRESS <u>Joseph V. Carter, Mt. Savage, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT (Specify)

SUICIDE  
HOMICIDEPLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

CITY OR TOWN

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15, 1951, to 3/5, 1951 that I last saw the deceasedalive on 3/5, 1951, and that death occurred at A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

Burial

## DATE THEREOF

3-8-1951

## NAME OF CEMETERY OR CREMATORY

St. Patricks

## LOCATION (City, town, or county)

Mt. Savage, Md.

(State)

## DATE REC'D BY LOCAL REG.

March 8, 1951

## REGISTRAR'S SIGNATURE

Walter A. Parry, M.D.

## 24. FUNERAL DIRECTOR

Jacob Hafer

## ADDRESS

Frostburg, Md.

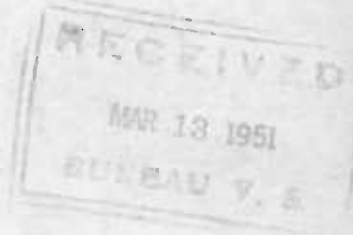
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

634439

*Dr. Poyner*



DR. RANSOM

## MARYLAND STATE DEPARTMENT OF HEALTH

02117

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY <b>ALLEGANY</b> STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
TOWN <b>CUMBERLAND, MD.</b>		TOWN <b>CUMBERLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		STREET ADDRESS (If rural, give location) <b>16 LOCUST STREET</b>	
3. NAME OF DECEASED (Type or Print) <b>STEVEN ROYCE CLAYTON</b>		4. DATE OF DEATH <b>3 13 1951</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>3/11/51</b>	
9. AGE last birthday <b>2</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ROYCE CLAYTON JR.</b>		14. MOTHER'S MAIDEN NAME <b>BETTY JANE NINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

776x Immediate cause (a) **Prematurity**

159 Antecedent cause(s) (b) **Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last**

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **3, 11**, 19**51**, to **3, 13**, 19**51**, that I last saw the deceased alive on **3, 13**, 19**51**, and that death occurred at **3:20 P** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>3-14-1951</b>	<b>Hillcrest Cem.</b>	<b>Cumberland, Md</b>	
DATE RECD BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>March 14, 1951</b>	<b>Walter L. Ransom, M.D.</b>	<b>Charles L. George, Cumberland, Md</b>		

203111271222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 20 1951  
BUREAU T. J.

George Allen

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02118

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> TOWN <b>Cumberland</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5307 1/2 Mechanic Street</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> TOWN <b>Cumberland</b> STREET ADDRESS <b>5307 1/2 Mechanic Street</b> (If rural, give location)	
3. NAME OF DECEASED (First) <b>Racheal</b> (Middle) <b>Connor</b> (Last) <b>Connor</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>12</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov 15, 1883</b>
9. AGE last birthday <b>67</b> yrs.		10. If under 1 year (Month) <b>67</b> (Day) <b>12</b> (Hours) <b>19</b> (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Racheal McBride</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY No. <b>none</b>	
17. INFORMANT <b>Thomas Connor</b>		<b>Cumberland, Md.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X Immediate cause

50

Antecedent cause(s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(a) **Carcinomatosis**  
(b) **Carcinoma of l. Breast**

INTERVAL BETWEEN ONSET AND DEATH

**1 yr**  
**since 1948**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <b>1-13-1948</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of breast &amp; axillary involvement</b>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **January, 1948**, to **3-12, 1951**, that I last saw the deceasedalive on **3-9-1951**, and that death occurred at **10:10 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Mar 15, 1951</b>		NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		LOCATION (City, town, or county) <b>Cumberland, Md.</b>	
DATE REC'D BY LOCAL REG. <b>March 14, 1951</b>		REGISTRAR'S SIGNATURE <b>Walter R. Sautz, M.D.</b>		24. FUNERAL DIRECTOR <b>M. Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD INTERNATIONAL TELEGRAPHIC

INTERNATIONAL TELEGRAPHIC

RECEIVED  
MAR 20 1951  
BUREAU

Dr. SCHINDLER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND, MARYLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		STREET ADDRESS (If rural, give location) <b>208 PEAR STREET</b>	
3. NAME OF DECEASED (Type or Print) <b>GEORGE H. DARR</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 7 1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 11 1879</b> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Rwy.</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>
13. FATHER'S NAME <b>JOHN DARR</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

430.1 Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Crown Thrombosis*  
 (b) *generalized arteriosclerosis*  
 (c)

INTERVAL BETWEEN ONSET AND DEATH

*4 days*  
*years*

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *March 3, 1951*, to *March 7, 1951*, that I last saw the deceased alive on *March 7, 1951*, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>3/9/51</b>	NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>	LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
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DATE REC'D BY LOCAL REG. <b>March 9, 1951</b>	REGISTRAR'S SIGNATURE <i>Walter K. Hartz, M.D.</i>	24. FUNERAL DIRECTOR <b>Charles L. George</b>	ADDRESS <b>Cumberland, Md.</b>
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695 506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNBAY V. B.

MAR 13 1951

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>AURELLIA</u> <u>DEVORE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>29</u> , 19 <u>51</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-17-1872</u>
9. AGE last birthday <u>79</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Crowe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Winebrenner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edna Plummer, Frostburg, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chc myocarditis</u>		<u>10 mo</u>
Antecedent cause(s) (b) <u>Arterio Sclerosis</u>		<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, 1951, to Mar 29, 1951, that I last saw the deceased alive on Mar 23, 1951, and that death occurred at 9:10 A m., from the causes and on the date stated above.

SIGNATURE Wm M Lane MD (Degree or title) ADDRESS Frostburg Md DATE SIGNED Mar 30 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4-1-1951</u>	NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-31-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Ross</u>	24. FUNERAL DIRECTOR <u>J. R. Durst, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 3 1951  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

02121

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Allegheny</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>5-8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>871 Maryland Ave</u>				STREET ADDRESS (If rural, give location) <u>871 Maryland Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Dolan</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>4</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 2, 1882</u>	9. AGE last birthday <u>75</u> yrs. If under 1 year: Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	
13. FATHER'S NAME <u>Samuel Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Slider</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Hosea H. Dolan - Cumberland Ind</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## 600.0 Immediate cause

(a) Myocarditis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

932

(b) Pyelo-nephritis

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1950, to Feb. 4, 1951, that I last saw the deceasedalive on Feb. 4, 1951, and that death occurred at 12.27 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

March 7, 1951Walter R. Dancy, M.D.John J. Hofer - Cumberland IndInd

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MAR 13 1961  
BUREAU A 8

DR. GRACIE  
grove

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02122

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>WEST VIRGINIA</b> COUNTY <b>PRESTON</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>KEMPTON</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <b>MIKE</b> (Middle) <b>DRAGOVICH</b> (Last) <b>Sr.</b>		4. DATE OF DEATH (Month) <b>MAR.</b> (Day) <b>23</b> (Year) <b>1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12.18.94</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	9. AGE last birthday <b>56</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>PAUL DRAGOVICH</b>		14. MOTHER'S MAIDEN NAME <b>MARY BELEG Becan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <b>154x</b> (a) <b>Pneumonia</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
Antecedent cause(s) <b>46d</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <b>Carcinoma of rectum</b>	<b>6 months</b>
(c) <b>Asthma</b>	<b>10 yrs.</b>

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <b>2-26-51</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of rectum (Adeno)</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>INJURY</b>	PLACE (Home, farm, factory, street, or office hldg., etc.) <b>INJURY</b>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-18**, 19**51**, to **3-23**, 19**51**, that I last saw the deceased

alive on **3-22**, 19**51**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

SIGNATURE **Dr. Gracie** ADDRESS **Cumberland** DATE SIGNED **3-23-51**

23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>March 28, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem</b>	LOCATION (City, town, or county) (State) <b>Thomas, Md.</b>
DATE REC'D BY LOCAL REG. <b>March 23, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Hank, M.D.</b>	24. FUNERAL DIRECTOR <b>J. D. Duncan</b>	ADDRESS <b>Thomas, Md.</b>

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MAR 27 1951  
BUREAU

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02123

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>332 AVIRETT AVE.</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>HERBERT Alroy DYE Jr.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 19 1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 6. 1879</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Police Manager</b>		9b. AGE last birthday <b>72</b> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>THORNTON DYE</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Chronic valvular Heart Disease</b>	<b>60 years</b>
Antecedent cause(s) (b) <b>with cerebral failure</b>	
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, or office bldg., etc.) <b>INJURY</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1946**, 19 **19**, to **19** **19**, that I last saw the deceased alive on **19** **19**, 19 **51**, and that death occurred at **10:15** p.m., from the causes and on the date stated above.

SIGNATURE **Dr. Alfred Van Ormer** ADDRESS **Cumberland, Md.** DATE SIGNED **2/25/51**

23. BURIAL CREATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>March 22, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Chilose (Md.)</b>	LOCATION (City, town, or county) (State) <b>Westernport Md.</b>
DATE REC'D BY LOCAL REG. <b>March 22, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Hantz, M.D.</b>	24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>	ADDRESS <b>Cumb. Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02124

*Trevaskis*

1. PLACE OF DEATH- COUNTY <i>Allegheny</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md</i> COUNTY <i>Allegheny</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cumberland</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cumberland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>440 N. Mechanic St.</i>		STREET ADDRESS (If rural, give location) <i>440 N. Mechanic St.</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Henrietta</i> (Middle) (Last) <i>Edenhart</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>March 18 1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 1, 1888</i>
9. AGE last birthday <i>62</i> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>near Mt. Savage, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Steele</i>		14. MOTHER'S MAIDEN NAME <i>Minnie L. Hubbard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Charles H. Edenhart, Cumberland, Md</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

*(a) Chronic Nephritis*

INTERVAL BETWEEN ONSET AND DEATH

*2 years*

## Antecedent cause(s)

*(b) Chronic myocarditis**2 years*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan 1*, 19*50*, to *Mar 18*, 19*51*, that I last saw the deceasedalive on *Mar 16*, 19*51*, and that death occurred at *11:30* a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*R. W. Trevaskis, Jr.**Cumberland**Maryland 3/19/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Mar 21, 1951</i>	NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>	LOCATION (City, town, or county) <i>Cumberland, Md.</i>	(State)
DATE REC'D BY LOCAL REG. <i>March 20, 1951</i>	REGISTRAR'S SIGNATURE <i>Walter L. Stantz, M.D.</i>	24. FUNERAL DIRECTOR <i>John G. Hofer, Cumberland, Md.</i>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02125

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Allegany Hospital</b>		STREET ADDRESS (If rural, give location) <b>Windsor Hotel</b>	
3. NAME OF DECEASED (Type or Print) <b>EDWIN</b> (First) <b>EYMAN</b> (Last)		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>23</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 23, 1872</b>
9. AGE last birthday <b>78</b> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Florist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pennsylvania</b>
13. FATHER'S NAME <b>John Eyman</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Mr. Frank Eyman, Cumberland, Maryland</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wayne</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Coronary occlusion**

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Mar. 19, 1951**, to **Mar. 22, 1951**, that I last saw the deceasedalive on **Mar. 22, 1951**, and that death occurred at **5:30 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Cumberland, Maryland****3/23/51**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>March 26, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Brush Creek Cemetery</b>	LOCATION (City, town, or county) <b>Manor, Pennsylvania</b>	(State)
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DATE REC'D BY LOCAL REG. <b>March 23, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Dantz, M.D.</b>	24. FUNERAL DIRECTOR <b>John C. Wolford, Cumberland, Maryland</b>	ADDRESS
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02126

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Illinois</u> COUNTY <u>Cook</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellerslie Chicago</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Helen</u> (Middle) <u>G.</u> (Last) <u>Farnham</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 27-1872</u>
9. AGE last birthday <u>78</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Interior Decorator</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edmund L. Farnham</u>	
14. MOTHER'S MAIDEN NAME <u>Bridget Clark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>342-22-4530</u>		17. INFORMANT AND ADDRESS <u>Mrs. Graham Stewart, Ellerslie, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Subdural hemorrhage due to fractured</u>		<u>2.1/2 hrs</u>	
Antecedent cause(s) (b) <u>Fractured of the skull also had a fracture</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>right of left pubic bone.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> (CITY OR TOWN) <u>Ellerslie</u> (COUNTY) <u>Allegany</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) <u>March 9/51</u> P. m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Crossing highway</u>		<u>walked into right rear side of truck</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>H.V. Deming M.D.</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE SIGNED <u>March 9-1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/14/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		LOCATION (City, town, or county) <u>ST. PAUL</u> (State) <u>MINN.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>March 12, 1951</u>		24. FUNERAL DIRECTOR <u>Harvey H. Ziegler</u>	
ADDRESS <u>HYNDMAN, Pa</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

564246

100-20-1051  
MAY 20 1951

RECEIVED  
C. A. F. O. V.

DR. SIMONS

## MARYLAND STATE DEPARTMENT OF HEALTH

02127

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>WEST VIRGINIA</b> COUNTY <b>Mineral</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND MARYLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>WILEY FORD</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		STREET ADDRESS (If rural, give location) <b>Wiley Ford, W.Va.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>EMMA</b> (Middle) <b>S</b> (Last) <b>FAUGHT</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 3 1951</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 3, 1874</b>
9. AGE last birthday <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA, Beckett</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>DAVID MILLER</b>		14. MOTHER'S MAIDEN NAME <b>HESTER EUTSLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

**Coronary Occlusion**

INTERVAL BETWEEN ONSET AND DEATH

**6 hrs.**

## Antecedent cause(s)

(b)

**Unilateral Hernia, strangulated****3 weeks**

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
**INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY  
**m.**INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan**, 19**51**, to **3/3**, 19**51**, that I last saw the deceased alive on **3/3**, 19**51**, and that death occurred at **2:15 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**March 5, 1951**  
**Charles R. Rantz, M.D.**

**James F. Scarpelli**  
**Cumberland, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAY 13 1961  
BUREAU A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02128

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504 Washington Street</u>		STREET ADDRESS (If rural, give location) <u>504 Washington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jean</u>	(Middle) <u>Anne</u>	(Last) <u>Ford</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 22 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	9. AGE last birthday <u>20</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cumberland Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Long</u>		14. MOTHER'S MAIDEN NAME <u>Irene Daily</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Harold Ford Cumberland, Maryland</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cervix-epithelioma</u>		<u>About</u>
173x Antecedent cause(s) (b) <u>48h</u>		<u>5-6 mo</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24-1951, to 3-19-1951, that I last saw the deceased alive on 3-19-1951, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

REG. March 20, 1951 Walter R. Tandy, M.D. William H. Rigt, Cumberland, Md.

Within corporate limits

The correct page

Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED  
MAR 27 1951  
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02129

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>527 Fayette St.</b>		STREET ADDRESS (If rural, give location) <b>527 Fayette St.</b>	
3. NAME OF DECEASED (Type or Print) (First) <b>Albert</b> (Middle) <b>Reece</b> (Last) <b>Franck</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>3</b> (Year) <b>1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Sept. 11-1910</b>
9. AGE last birthday <b>40</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research chemist Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Lake Port, California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Max Franck</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Case</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>214-07-6895</b>	
17. INFORMANT AND ADDRESS <b>mother Gladys Case Franck</b>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <b>Immediate cause</b> <b>Coronary occlusion due to</b>		<b>at once</b>
(b) <b>Antecedent cause(s)</b> <b>Coronary sclerosis</b>		<b>?</b>
(c) <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md.

March 3-1951

23. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>	DATE THEREOF <b>3/7/1951</b>	NAME OF CEMETERY OR CREMATORY <b>J. W. Lee's Sons Co.</b>	LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
---	---------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>March 6, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Hartz, M.D.</b>	24. FUNERAL DIRECTOR <b>William H. Kight</b>	ADDRESS <b>Cumberland, Md.</b>
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007466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC-11  
MAR 13 1951  
RECEIVED A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02130

## CERTIFICATE OF DEATH

Reg. Dist. No. .... ✓ .....

1. PLACE OF DEATH COUNTY <u>Alleghany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> <u>Alleghany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oldtown Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oldtown, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#1 Oldtown, Md</u>		STREET ADDRESS <u>R.F.D.#1 Oldtown, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Fulk</u> (Middle) (Last)		4. DATE OF DEATH <u>March</u> (Month) <u>4</u> (Day), 19 <u>51</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Old jobs</u>	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>723-14-4738</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Fyles, Oldtown, Md. Rt. #1</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocarditis (Senile)</u>		
Antecedent cause(s) (b) <u>None</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1951, to 3/4, 1951, that I last saw the deceased alive on 3/4, 1951, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Oldtown Meth. Cem.</u>	LOCATION (City, town, or county) (State) <u>Oldtown, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 6, 1951</u>	REGISTRAR'S SIGNATURE <u>Thos. S. E. C. Ginevan</u>	24. FUNERAL DIRECTOR <u>James F. Scarpelli</u>	ADDRESS <u>Cumberland, Md.</u>

3/7/51

970 vvv

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 9 1961  
BUREAU A. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02131 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>128 Bowery St.</u>		STREET ADDRESS (If rural, give location) <u>128 Bowery St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HARRY</u>	(Middle) <u>SANNER</u>	(Last) <u>FULLER</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>9-26-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired stonemason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>	9. AGE last birthday <u>77</u> yrs.
13. FATHER'S NAME <u>James Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Anne Worsing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>217-05-7656</u>	
17. INFORMANT AND ADDRESS <u>Timothy Fuller, Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arterio Sclerosis</u>			<u>2 years</u>
Antecedent cause(s) (b) <u>450.0</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>97</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1949, 19....., to Mar 13, 1957, that I last saw the deceased alive on Mar 2, 1957, and that death occurred at 3:20 m., from the causes and on the date stated above.

SIGNATURE Wm Lane MD (Degree or title) ADDRESS Frostburg Md DATE SIGNED Mar 14 1957

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-16-1951</u>	<u>F'bg. Memorial Park</u>	<u>Frostburg,</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-16-51</u>	<u>Mr. Nancy V. Roe</u>	<u>J. R. Durst,</u>	<u>Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

504246

MAR 20 1951  
BUREAU

MAR 20 1951  
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

02132

Reg. Dist. No. 4

The correct age of the deceased must be given. The correct age of the deceased must be given. The correct age of the deceased must be given.

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Queen City Hotel</b>		STREET ADDRESS (If rural, give location) <b>Queen City Hotel</b>	
3. NAME OF DECEASED (Type or Print) <b>Bertha Ann Gates</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>21</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 31-1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook at Bolt &amp; Forge</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O.R.Ry.</b>	9. AGE last birthday <b>59</b> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>King</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>170-12-3877</b>	
17. INFORMANT AND ADDRESS <b>son) William Weber, Altoona, Pa.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Coronary occlusion due to</b>		<b>at once</b>
Antecedent cause(s) (b) <b>Coronary sclerosis</b>		<b>about 3</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Arteriosclerosis with hypertention</b>		<b>yrs.</b>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <b>H.V. Deming M.D.</b>		ADDRESS <b>Cumberland, Md.</b>		DATE SIGNED <b>March 21-1951</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>March 24, 1951</b>		NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>	
LOCATION (City, town, or county) <b>Altoona</b>		(State) <b>Pa</b>			
24. FUNERAL DIRECTOR <b>John J. Hager, Cumberland, Md.</b>		ADDRESS <b>Altoona, Pa.</b>			

754506



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

02183

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE, near Cumberland, rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS <b>BRADDOCK FARMS</b>	
3. NAME OF DECEASED (First) <b>ELIZABETH</b> (Middle) <b>A</b> (Last) <b>GELLNER</b>		4. DATE OF DEATH <b>MARCH 31 1951</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, <b>MARRIED</b> (Specify)	8. DATE OF BIRTH <b>APRIL 16, 1886-70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE last birthday <b>64</b> If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Annapolis</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER NOLAN</b>		14. MOTHER'S MAIDEN NAME <b>JOHANNA COLLINS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>The metastatic Carcinoma</b>	<b>Under</b>
Antecedent cause(s) (b) <b>Carcinoma Breast</b>	<b>Under</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>16 Degenerative metabolic</b>	<b>Under</b>
II <b>Arteriosclerosis</b>	<b>Under</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b> PLACE (Home, farm, factory, street, or office bldg., etc.) <b>INJURY</b> (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b> INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2-26**, 19**57**, to **3/31**, 19**57**, that I last saw the deceased alive on **3/30**, 19**57**, and that death occurred at **2:03** A.M., from the causes and on the date stated above.

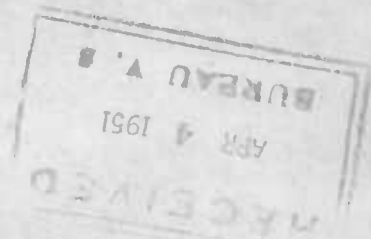
SIGNATURE **J. H. Rees, M.D.** (Degree or title) ADDRESS **404 Reisterstown Rd., Baltimore 4, Md.** DATE SIGNED **4/1/57**

23. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	DATE THEREOF <b>Apr. 2, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>St. Peter + Pauls Cem.</b>	LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)
DATE RECD BY LOCAL REG. <b>April 1, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter L. Smith, M.D.</b>	24. FUNERAL DIRECTOR <b>Louis Steer, Inc.</b>	ADDRESS <b>Cumbr. Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Stein



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02134

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Cummary</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> ALLEGENTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> STREET ADDRESS <u>934 Maryland, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Eliza</u> (First) <u>J.</u> (Middle) <u>Gilpin</u> (Last)		4. DATE OF DEATH <u>3/7/51</u> (Month) (Day) (Year) 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH <u>May 17, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Chaneyville, Pa.</u>
13. FATHER'S NAME <u>Daniel Wrightsman</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Walters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>Unknown</u> ) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Dorthy Wilson Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Influenza, Virus Type

## Antecedent cause(s)

(b) Myocarditis

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/2/51, 1951, to 3/7, 1951, that I last saw the deceasedalive on 3/7, 1951, and that death occurred at 10:00 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/10/51</u>	<u>Plesent Valley Cem.</u>	<u>Near Mt. Lake Park, Md.</u>	<u>MD</u>

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 9, 1951 Winters R. Dantz, Md. James F. Scarpelli Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 13 1951  
LIBRARY A 2

Outside of  
City Limits

Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

02135

2411 N. Charles Street, Baltimore

FILE No. G 1, 1 MAR 27 1951

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. D. #4 Mexico Farms.</u>		STREET ADDRESS (If rural, give location) <u>R. D. #4 Mexico Farms</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>LOUELLA</u> (Middle) <u>YOUNG</u> (Last) <u>GOLDEN</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Mar. 12, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 3, 1865</u>
9. AGE last birthday <u>86</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert L. Young</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Russell Hymes, R.D. #4 Cumb. Md.</u>			

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) Coronary Occlusion due to weakening of heart due to

INTERVAL BETWEEN ONSET AND DEATH

#### Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cold & Influenza (3/29/51 akc)

(c) Exertion climbing stairs caused heart attack

5 minutes

6 days

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 9, 1951, to March 12, 1951, that I last saw the deceased

alive on March 9, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cem.</u>	LOCATION (City, town, or county) <u>Cumberland, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 15, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hanky M.D.</u>	24. FUNERAL DIRECTOR ADDRESS <u>Charles L. George Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

GoH Licb  
02136

Reg. Dist. No. 4

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Alleg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>167 N. Centre St</u>		STREET ADDRESS (If rural, give location) <u>167 N. Centre St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GoH Lieb, Sarah</u>	(Middle)	(Last) <u>GoH Lieb</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 1 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>78</u> yrs. <u>2</u> months <u>1</u> days
11. FATHER'S NAME <u>Herman White</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Betty Levi</u>		14. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Joseph White, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause	(a) <u>Acute left ventricular failure</u>	<u>2 hours</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Myocardial fibrosis due to Coronary Insufficiency</u>	<u>2 years</u>	
	(c) <u>Aortic Insufficiency</u>	<u>and 5 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Aortic Insufficiency</u>			<u>? Childhood</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March, 1950, to April 2, 1951, that I last saw the deceased alive on March, 1951, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE Levell G. Weissman (Degree or title) ADDRESS 59 Greene St Cumberland, Md DATE SIGNED April 2, 1951

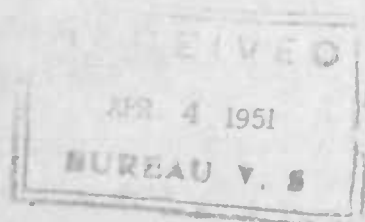
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 2 1951</u>	NAME OF CEMETERY OR CREMATORY <u>East View Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
DATE REC'D BY LOCAL REG. <u>April 2, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Lang, M.D.</u>	24. FUNERAL DIRECTOR <u>Louis Stein, Inc.</u>	ADDRESS <u>Cumberland, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.



DR. ENFIELD

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02137

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b>		STATE <b>MARYLAND</b>		COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>		LENGTH OF STAY (in this place) <b>7 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>131 PENNSYLVANIA AVENUE</b>			
3. NAME OF DECEASED (Type or Print) <b>EDWARD</b>		(First) <b>R.</b>		(Last) <b>HAHNE</b>	
4. DATE OF DEATH <b>MARCH</b>		(Month) <b>4,</b>		(Day) <b>51</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>FEB. 19, 1894</b>		9. AGE last birthday <b>57</b> yrs.		10. If under 1 year Months   Days   Hours   Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O.R.R.CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT Country? <b>USA</b>		13. FATHER'S NAME <b>AUGUST M. HAHNE</b>			
14. MOTHER'S MAIDEN NAME <b>CHRISTINA HESS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY No. <b>705-09-8660</b>		17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

585x Immediate cause

(a) *Paralytic Ileus.*122x Antecedent cause(s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) *Gangrenous Gall Bladder*II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.(c) *Excess of High Blood Pressure*

## 19a. DATE OF OPERATION

2/26/57

## 19b. MAJOR FINDINGS OF OPERATION

*Gangrenous Gall Bladder*

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT/  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 26, 1957, to April 4, 1957, that I last saw the deceased

alive on March 3, 1957, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

3/7/57

NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

LOCATION (City, town, or county)

Cumberland, Md.

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

Walter L. Frank, M.D.

FUNERAL DIRECTOR

James T. Scarpelli Cumberland, Md.

544506

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED  
MAR 13 1961  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02138

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegheny Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> TOWN <u>Cumberland</u> STREET ADDRESS (If rural, give location) <u>511 Fayette St.</u>	
3. NAME OF DECEASED (Type or Print) <u>ADDIE</u> (First) <u>Hammer</u> (Middle) <u>Smith</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 4, 1867</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hoffgang Hammersmith</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Emma Hammersmith</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

422.1 Antecedent cause(s)  
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(a) Chronic myo-carditis

(b) Atherosclerosis

(c)

## INTERVAL BETWEEN ONSET AND DEATH

2 years

2 years

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 2, 1951, to Mar 29, 51, that I last saw the deceased alive on Mar 28, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 30, 1951Walter K. Karty, M.D.Louis Stun Inc.Cumb. Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED  
JUN 4 1951  
BUREAU V. B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

02139

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 Columbia St.</u>		STREET ADDRESS (If rural, give location) <u>113 Columbia St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Matthew</u>	(Middle) <u>John</u>	(Last) <u>Haslbeck</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 21-1868</u>
9. AGE last birthday <u>82</u> yrs.		4. DATE OF DEATH <u>March 1 1951</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired salesman, C.D. Kenney Wholesale</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Haslbeck</u>		14. MOTHER'S MAIDEN NAME <u>Eva Kroller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs Lawrence Haslbeck</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>at once</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>6</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md.March 1-1951

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 3 1951</u>	<u>Holy Redeemer Cem</u>	<u>Baltimore Maryland</u>

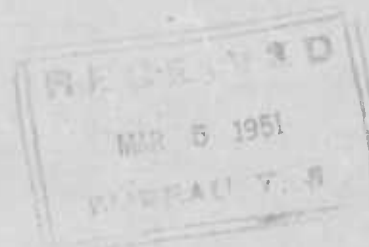
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>March 3, 1951</u>	<u>Walter R. Lantz, M.D.</u>	<u>William H. Kight</u>	<u>Cumberland, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

490609



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02140

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cumberland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6 Race St.</b>		STREET ADDRESS (If rural, give location) <b>6 Race St.</b>	
3. NAME OF DECEASED (Type or Print) <b>James Edgar Holliday</b>		4. DATE OF DEATH (Month) <b>Mar.</b> (Day) <b>29</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-1-1989</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Box Factory</b>	9. AGE last birthday <b>61</b> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Berkley Springs, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Holliday</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Boor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Unknown</b>		16. SOCIAL SECURITY NO. <b>214-07-3868</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Carrie Holliday Cumberland, Md.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

**Cirrhosis of Liver**

## Antecedent cause(s)

(b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

**3 mo**II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan 12**, 1951, to **Mar. 29**, 1951, that I last saw the deceased alive on **Mar. 24**, 1951, and that death occurred at **5:30** a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>4-1-1951</b>	<b>Zion Memorial Cem.</b>	<b>Cumberland, Md.</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>March 31, 1951</b>	<b>Walter R. Dancy, M.D.</b>	<b>Charles L. George</b>	<b>Cumberland, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FIVED

APR 4 1951

BUREAU V. 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02141

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>128 E. Main St.</u>		STREET ADDRESS (If rural, give location) <u>128 E. Main St.</u>	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>KEAR</u> (Last) <u>HOSKEN</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>9-27-1890</u>
9. AGE last birthday <u>60</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>watchmaker-jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own jewelry store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George K. Hosken</u>		14. MOTHER'S MAIDEN NAME <u>Venie Fuller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Martha Hosken, Frostburg, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>				<u>Sudden</u>	
Antecedent cause(s) (b) <u>Coronary Sclerosis</u>				<u>6 mo</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic Myocarditis Hypertension</u>				<u>2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>None</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1949, to Mar 1, 1951, that I last saw the deceased alive on Feb 28, 1951, and that death occurred at 1:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) WOMC Lane MD ADDRESS Frostburg Md DATE SIGNED 3-2-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3-3-51</u>	NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem'l Park</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>	(State)
DATE REC'D BY LOCAL REG <u>3-3-51</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Re</u>	24. FUNERAL DIRECTOR <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>

534817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 8 1961  
AIR MAIL

## 02142

Reg. Dist. No. 7

## Reg. Dist. No. 7

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Acute Cardiac Distention</u>		<u>2 Days</u>	
Antecedent cause(s)		(b) <u>Chronic Cardiac</u>		<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
				(CITY OR TOWN)	
				(COUNTY)	
				(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 26, 1957</u> to <u>Mar 31, 1957</u> , that I last saw the deceased alive on <u>Mar 31, 1957</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
<u>Wm L. Lane M.D.</u>		<u>Frostburg Md</u>		<u>Apr 2 1957</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>4-3-57</u>		<u>F'bg. Memorial Park</u>	
				LOCATION (City, town, or county)	
				<u>Frostburg, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>4-3-57</u>		<u>Wm. Nancy H. Roe</u>		<u>J. R. Durst,</u>	
				ADDRESS	
				<u>Frostburg, Md.</u>	

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 9 1951  
BUREAU T. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02143

Reg. Dist. No. 8

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gilmore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gilmore</u>	
TOWN <u>Gilmore</u>		TOWN <u>Gilmore</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Joseph</u> (Middle) <u>H.</u> (Last) <u>Jenkins</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 22, 1882</u>
9. AGE last birthday <u>78</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Bond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Joseph Jenkins Jr</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Acute Congestive Heart failure

## INTERVAL BETWEEN ONSET AND DEATH

30 hrs.

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Influenza10 days(c) Silicosis & asthmayears

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 26 March, 1951, to 30 March, 1951, that I last saw the deceased alive on 30 March, 1951, and that death occurred at 9:10 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	LOCATION (City, town, or county) <u>Frostburg</u>	(State) <u>Md</u>
DATE RECD BY LOCAL REG. <u>4/1/51</u>	REGISTRAR'S SIGNATURE <u>Garette M. Boal</u>	24. FUNERAL DIRECTOR <u>M. Eichhorn</u>	ADDRESS <u>Lonaconing, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
APR 9 1951  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02144

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shaft</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shaft</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>96.701 Frothingham</u>		STREET ADDRESS (If rural, give location) <u>96.701 Frothingham, Ind.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Laura</u> (Middle) <u>Alice</u> (Last) <u>Pers</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-23-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>64 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Shaft, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. McPerrine</u>		14. MOTHER'S MAIDEN NAME <u>Charles Gear</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John T. Pers, Shaft, Ind.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensionseveral years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 26, 1951, to Mar 27, 1951, that I last saw the deceasedalive on Mar 26, 1951, and that death occurred at 7:00 A.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

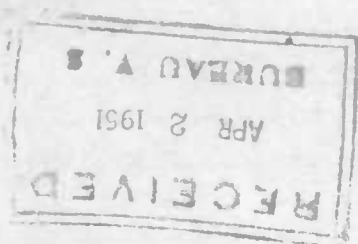
ADDRESS

3-29-51Mr. Nancy N. RoeJacob W. W. Frothingham, Ind.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, ~~WITH~~ UNFADING INK. Supply every item of information carefully. is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

02145

Reg. Dist. No. .... 4 .....

FILM No. G 132 APR 13 1951 CERTIFICATE OF DEATH

1. PLACE OF DEATH- COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Route 1, Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Route 1, Cumberland</u> <u>rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Red Hill</u>		STREET ADDRESS (If rural, give location) <u>Red Hill</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>GEORGE</u>		<u>B.</u>	<u>KNEE</u>
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>March 27, 1951</u>		<u>19</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 15, 1865</u>
9. AGE last birthday	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
<u>85</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Timber Cutter</u>	<u>Logging ind.</u>	<u>Chaneysville, Pa.</u>	<u>USA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Phillip Knee</u>		<u>Mary??</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS	
<u>No</u>	<u>None</u>	<u>Mrs. Leo Donahoe, Cumberland, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bronchitis</u>												4 days	
Antecedent cause(s) (b) <u>Fall injury to Back</u>												12 weeks	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>													
II. OTHER SIGNIFICANT CONDITIONS													
Conditions contributing to the death but not related to the disease or condition causing death. <u>Smoking</u>													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?			
										Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)				(CITY OR TOWN)		(COUNTY)		(STATE)	
SUICIDE accident				INJURY home						all.		md	
TIME (Month) (Day) (Year)				INJURY OCCURRED		HOW DID INJURY OCCUR?							
OF INJURY Jan 1951				While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		slipped and fell							

22. I hereby certify that I attended the deceased from Jan, 1957, to March 27 1957, that I last saw the deceased alive on March 26, 1957, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE <i>Wm G Kight</i>		(Degree or title) D.D.		ADDRESS <i>Cumberland, Md.</i>		DATE SIGNED <i>March 28</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>3/30/1951</i>		NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		LOCATION (City, town, or county) <i>Cumberland, Md.</i>	
DATE RECD BY LOCAL REG. <i>March 28, 1951</i>		REGISTRAR'S SIGNATURE <i>Wm G Kight</i>		24. FUNERAL DIRECTOR <i>William H. Kight</i>		ADDRESS <i>Cumberland, Md.</i>	

950306

RECEIVED

APR 4 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

02146

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>In water, at dam, east end of Furnace St.</u>		STREET ADDRESS (If rural, give location) <u>530 Reihl Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ronald</u> <u>Kieth</u> <u>Knippenberg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>20</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 19-1944</u>
9. AGE last birthday <u>6</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Knippenberg</u>		14. MOTHER'S MAIDEN NAME <u>Geraldine Wills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mother) Geraldine Knippenberg</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Asphyxia due to accidental drowning

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH  
about 5 min.11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>east end of Furnace St.</u>		(CITY OR TOWN) <u>Cumberland</u>	(COUNTY) <u>Allegany</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 20/51 P.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Playing, slipped on clay bank and fell in water, 8 ft.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. <u>H.V. Deming M.D.</u>		Cumberland, Md.		March 20-1951	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>March 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	LOCATION (City, town, or county) <u>Cumberland, Md.</u>	(State)	

DATE REC'D BY LOCAL REG. <u>March 22, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Haney, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hager, Cumberland, Md.</u>	ADDRESS
---	---	---	---------

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02147 9

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
TOWN <b>Frostburg</b>		TOWN <b>Frostburg</b>	
INSTITUTION OR STREET ADDRESS <b>Miners Hospital</b>		STREET ADDRESS (If rural, give location) <b>62 Bowery Street</b>	
3. NAME OF DECEASED (First) <b>ANNIE</b> (Middle) <b>KYLE</b> (Last) <b>KYLE</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>17</b> (Year) <b>1951</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>3-22-1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	9. AGE last birthday <b>68</b> yrs. If under 1 year 1 month, 2 days, 3 hours, 4 min.
13. FATHER'S NAME <b>JAMES STEVENS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		17. INFORMANT AND ADDRESS <b>John Kyle, Frostburg, Md.</b>	
16. SOCIAL SECURITY No. <b>none</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANN EDWARDS</b>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>420.1</b>	<b>Coronary occlusion</b>		<b>21 Days</b>
Antecedent cause(s) <b>94a</b>	<b>Coronary sclerosis</b>		<b>1 year</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1950**, 19....., to **MAR 17, 1951**, that I last saw the deceased alive on **MAR 17, 1951**, and that death occurred at **2:15 P.M.** m., from the causes and on the date stated above.

SIGNATURE <b>W. M. Lane M.D.</b>		ADDRESS <b>Frostburg Md.</b>		DATE SIGNED <b>3-19-51</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE <b>3-20-51</b>		NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>	
LOCATION (City, town, or county) <b>Frostburg, Md.</b>		24. FUNERAL DIRECTOR <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
DATE REC'D BY LOCAL REG. <b>3-20-51</b>		REGISTRAR'S SIGNATURE <b>W. Nancy X. Roe</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 26 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02148

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> LENGTH OF STAY (in this place) <u>30 yrs.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>624 Shriver Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u> STREET ADDRESS (If rural, give location) <u>624 Shriver Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Edgar</u> (Middle) <u>Lancaster</u> (Last)		4. DATE OF DEATH <u>Mar</u> (Month) <u>25</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 6, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield Co</u>	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Gilmore md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Martta Jenkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>214-07-0070</u>	
17. INFORMANT AND ADDRESS <u>Mrs John Lancaster Cumberland md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Chloran Cocaine</u>		<u>2 days</u>	
Antecedent cause(s) (b) <u>Myocardial failure</u>		<u>1 hr</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio Sclerosis</u>		<u>1 hr</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/5, 1951, to 3/25, 1951, that I last saw the deceased alive on 3/27, 1951, and that death occurred at 1:30 m. from the causes and on the date stated above.

SIGNATURE <u>R. C. Rees</u>		DATE SIGNED <u>3/28/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar 27, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Cumberland md</u>	
24. FUNERAL DIRECTOR <u>John J. Zager</u>		ADDRESS <u>Cumberland md</u>	
DATE REG'D BY LOCAL REG. <u>March 27, 1951</u>		REGISTRAR'S SIGNATURE <u>Walter R. Bantz, M.D.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

763 VVV

APR 4 1951  
BUREAU V. S.

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02149

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH - COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Cumberland Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Cumberland Rural</u>	
TOWN <u>West Cumberland Rural</u> LENGTH OF STAY (in this place) <u>27 years</u>		STREET ADDRESS (If rural, give location) <u>Route 3, Bowman's Addn.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bowman's Addn, R.F.D. #3</u>			
3. NAME OF DECEASED (First) <u>Clayton</u> (Middle) <u>Calvin</u> (Last) <u>Lee</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>13</u> (Year) <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 9, 1870</u>
9. AGE last birthday <u>80</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	11. BIRTHPLACE (State or foreign country) <u>Bedford Co., Pa.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. FATHER'S NAME <u>John Lee</u>	14. MOTHER'S MAIDEN NAME <u>Harriett Deal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT AND ADDRESS <u>Roy Lee, Wellersburg, Pa.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

422.1 Immediate cause (a) Chronic Myocardiosis & Generalized 8 yr

Antecedent cause(s) (b) Arterio Sclerosis

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11/20/50, 19....., to 3/13/57, 19....., that I last saw the deceased alive on 3/13/57, 19....., and that death occurred at 5:40 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 16, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Chaneyville Methodist Cemetery</u>	LOCATION (City, town, or county) <u>Chaneyville, Pa.</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 16, 1957</u>	REGISTRAR'S SIGNATURE <u>Walter R. Mandy, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hofer, Cumberland, Md.</u>	ADDRESS	

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Wagner



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02150

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>	
TOWN <b>CUMBERLAND</b>		TOWN <b>FROSTBURG</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL MEMORIAL AVE., CUMBERLAND, MD.</b>		STREET ADDRESS (If rural, give location) <b>13 CENTENNIAL STREET</b>	
3. NAME OF DECEASED (First) <b>WILLIAM</b> (Middle) <b>ROBERT</b> (Last) <b>LLEWELLYN, JR.</b>		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>2</b> (Year) <b>1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>FEBRUARY 25, 1935</b>
9. AGE last birthday <b>12</b> yrs.		10. If under 1 year: Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student - Cumberland School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM ROBERT LLEWELLYN, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>EVELYN SIGLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **acidosis, Dehydration**

Antecedent cause(s)

(b) **Diabetes**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) **SUICIDE**

PLACE (Home, farm, factory, street, OF office hldg., etc.) **INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **m.**

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 2, 1951**, to **March 2, 1951**, that I last saw the deceased

alive on **March 2, 1951**, and that death occurred at **12:00NOON**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Thomas Robinson**

**M.D.**

**132 S. Liberty St. Cumberland, Md**

**3/2/51**

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

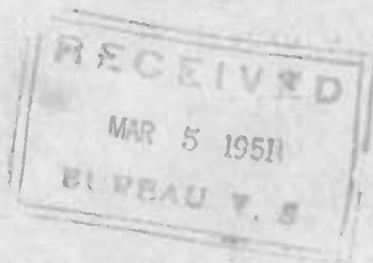
**March 3, 1951**

**Walter R. Treaty, M.D.**

**132 S. Liberty St. Cumberland, Md**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cumberland</b> LENGTH OF STAY (in this place) <b>5 days</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Allegany</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Frostburg,</b> STREET ADDRESS (If rural, give location) <b>86 Broadway</b>	
3. NAME OF DECEASED (Type or Print) <b>Angus</b> (First) (Middle) (Last) <b>McAtee</b>		4. DATE OF DEATH <b>March 3 19 51</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>S</b>	8. DATE OF BIRTH <b>4-2-1883</b>
9. AGE last birthday <b>67</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Turner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Angus McAtee</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Farrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT <b>Mrs. A. Kenney, 86 Broadway, Frostburg, Md.</b>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
584x Immediate cause (a) <b>Hepato-Renal Syndrome</b>			
126 Antecedent cause(s) (b) <b>cholelithiasis</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>2/28/51</b>	19b. MAJOR FINDINGS OF OPERATION <b>cholelithiasis</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2/20**, 19**51**, to **3/3**, 19**51**, that I last saw the deceased alive on **3/3**, 19**51**, and that death occurred at **5:05** a.m., from the causes and on the date stated above.

SIGNATURE **John Rogers M.D.** ADDRESS **Cumberland Md** DATE SIGNED **3/3/51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <b>3-6-1951</b>	NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>	LOCATION (City, town, or county) <b>Mt. Savage, Md.</b>
DATE REC'D BY LOCAL REG <b>March 5, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter K. Harty, M.D.</b>	24. FUNERAL DIRECTOR <b>Jacob Haier</b>	ADDRESS <b>Frostburg, Md.</b>

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 13 1961  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02152

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504 Washington St</u>		STREET ADDRESS (If rural, give location) <u>504 Washington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>Lester</u>	(Last) <u>McRae</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>19</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>	11. BIRTHPLACE (State or foreign country) <u>Shepardstown, W. Va.</u>
13. FATHER'S NAME <u>David McRae</u>		14. MOTHER'S MAIDEN NAME <u>Louisana Mask</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
		17. INFORMANT AND ADDRESS <u>Mrs James McRae, Cumberland, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Valvular Heart Disease</u> Antecedent cause(s) (b) <u>Disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic myocardial degeneration</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15-, 1939, to 3-19-, 1951, that I last saw the deceased alive on 3-18-, 1951, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams M.D. (Degree or title) ADDRESS Cumberland DATE SIGNED 3-19-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 21 1951</u>	<u>Hill Crest Burial Park</u>	<u>Cumberland, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 20, 1951</u>	<u>Walter A. Parry, M.D.</u>	<u>William. H. Kight</u>	<u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290 399



# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

02153

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>rear 339 Fredrick St.</u>		STREET ADDRESS (If rural, give location) <u>rear, 339 Fredrick St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Kelly</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>7</u> <u>1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>bad jobs</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>old chart in hospital.</u>			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion due to</u>			<u>at once</u>
Antecedent cause(s) (b) <u>generalized arteriosclerosis</u>			<u>?</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>March 26-1951</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Allegany County Cem.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
<u>March 28, 1951</u>		<u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>William H. Kight, Cumberland, Md.</u>			

970 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5150

APR 4 1951

BUREAU V. B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02154

9

## 1. PLACE OF DEATH:

County alleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hrs. 16 min.

Hospital, institution, or street address where death occurred:

minus HospitalHow long in hospital or institution? 6 hrs. 16 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleg.City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. minus Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war At. 2, Box 487

## 3. (a) FULL NAME

Baby Boy Morgan (Premature birth)

## 3. (b) Social Security Number

none

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Premature infant</u>
--------------------	------------------------------	---

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 3-6 1951, at 4:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-6 1951 to 3-6 1951and that I last saw h. i. m. alive on 3-6 1951Immediate cause of death Premature birth (25 weeks)Breath delivery

Due to

Other conditions

761.5  
(Include pregnancy within 3 months of death)

Major findings ul operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Diehl M.D.Address Frostburg, Md. Date signed 3/6/51

## 11. Industry or business

Infant12. Name James Edward Morgan13. Birthplace Valh Summit - Md.14. Maiden name Betty Lou Hyde15. Birthplace Frostburg, Md.16. Informant Mrs. James E. MorganAddress Rt 2 Box 487, Frostburg, Md.17. Burial Date thereof 3-8-51

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Frostburg Memorial ParkLocation Frostburg, Md.19. Funeral director Jacob SkilleAddress Frostburg19. 3-7 1951 Wm. Haucy V. Roe

(Date rec'd by registrar) Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02155

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural, give location) <u>601 North Mechanic St</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>Matthew</u> (Last) <u>Nimick</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/20/1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Digging graves</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St Peter &amp; Paul Cemetery</u>	9. AGE last birthday <u>65</u> yrs. If under 1 year Months. Days Hours Min.
13. FATHER'S NAME <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>g</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No. <u>214-14-7853</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs Daisy Nimick Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Pyelo nephritis</u>		<u>1 wk</u>
Antecedent cause(s) (b) <u>600.0</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>133a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 16, 1951, to Mar 20, 1951, that I last saw the deceased alive on Mar 20, 1951, and that death occurred at 6:30 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

March 22, 1951 Winters & Son, M.D. William H. Kight, Cumberland, Md.

970746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02156

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>OLDTOWN</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <b>LAWSON</b> (Middle) <b>C.</b> (Last) <b>NIXON</b>		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>17</b> (Year) <b>1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>OCT. 13, 1889</b>
9. AGE last birthday <b>61</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>His farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>COLUMBUS C. NIXON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA LEASURE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Parkinson's Disease**

INTERVAL BETWEEN ONSET AND DEATH

**19 years**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **1940**, 19, to **17 Mar.**, 19**51**, that I last saw the deceased alive on **16 Mar.**, 19**51**, and that death occurred at **6:00 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**W. Alfred Van Ormer****Cumberland, Md.****17 Mar. 51**

23. BURIAL CREMATION REMOVAL (Specify) <b>Reinterment</b>	DATE THEREOF <b>3/20/51</b>	NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>
DATE REG'D BY LOCAL REG. <b>March 20, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Hantz, M.D.</b>	24. FUNERAL DIRECTOR <b>Louis Stein, Inc.</b>	ADDRESS <b>Cumberland, Md.</b>

290116

MARGIN RESERVED FOR BINDING

VS. A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Stein has been called



ELIASON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02157

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND, MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (First) <u>KAY</u> (Middle) <u>ELLEN</u> (Last) <u>PAUL</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>8-10-48</u>
9. AGE last birthday <u>21 1/2</u> yrs.		10. If under 1 year: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>MEYERSDALE, PA.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH W. PAUL</u>		14. MOTHER'S MAIDEN NAME <u>HELEN WITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Miliary TuberculosisAntecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) INTERVAL BETWEEN ONSET AND DEATH 4 WksII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from 3-4, 1951, to 3-6, 1951, that I last saw the deceased alive on 3-6, 1951, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE N. W. Elason

(Degree or title)

ADDRESS 126 1/2 North Cumberland MdDATE SIGNED 

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Old Fellows Cem</u>	LOCATION (City, town, or county) <u>Salisbury, Tennessee</u>	(State) <u>Tennessee</u>
DATE REC'D BY LOCAL REG. <u>March 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter E. Harty, M.D.</u>	24. FUNERAL DIRECTOR <u>Wm Wintersburg Grantsville</u>	ADDRESS <u></u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 13 1961  
BUREAU OF

When corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02158

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural, give location) <u>512 Eastern Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Agnes</u> (Last) <u>Perden</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 2, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkinsville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Unknown Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Charles H. Perden, Cumberland, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis  
Antecedent cause(s) (b) Atherosclerosis  
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

3 wks

3 yrs

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 3, 1951, to Jan 4, 5, 1951, that I last saw the deceased alive on Jan. 3, 1951, and that death occurred at 1130 a.m., from the causes and on the date stated above.

SIGNATURE Clay J. Summitt M.D. ADDRESS Cumberland DATE SIGNED 3/7/51

23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>March 7, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Pleasant Methodist Cemetery</u>	LOCATION (City, town, or county) (State) <u>near Cumberland, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Parry, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hofer, Cumberland, Md.</u>	ADDRESS

VS. A15-1

*Rev. Burnett.*

MAR 13 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02159

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Frostburg</u> TOWN <u>Frostburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> TOWN <u>Frostburg</u> STREET ADDRESS (If rural, give location) <u>R.F.D. #2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jesse</u>	(Middle) <u>Hiram</u>	(Last) <u>Pfaff</u>
6. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April-4-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>	9. AGE last birthday <u>62</u> yrs.
13. FATHER'S NAME <u>Conrad Pfaff</u>	14. MOTHER'S MAIDEN NAME <u>Jenny Luning</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>213-69-6454</u>
17. INFORMANT AND ADDRESS <u>Charles Pfaff - R.F.D. #2, Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Hodgkin's Disease

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1949, 19....., to 1951, 19....., that I last saw the deceasedalive on Febr. 10, 1951, and that death occurred at 12:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-31-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-31-51</u>	REGISTRAR'S SIGNATURE <u>Wm. Harvey Roe</u>	24. FUNERAL DIRECTOR <u>Jacob Hafer</u>	ADDRESS <u>Frostburg, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

650216

RECEIVED  
APR 3 1951  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02160

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>WEST VIRGINIA</b> COUNTY <b>MINERAL</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>RIDGELEY</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>202 MAIN STREET</b>	
3. NAME OF DECEASED (Type or Print) <b>DAVID</b> (First) <b>Wesley</b> (Middle) <b>PHILLIPS</b> (Last)		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>15</b> (Year) <b>1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>FEB. 6, 1951</b>
9. AGE last birthday <b>5 WEEKS</b>		10. AGE last birthday If under 1 year Months <b>5</b> Days <b>10</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MARION L. PHILLIPS</b>		14. MOTHER'S MAIDEN NAME <b>ELEANOR JANE PERRY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Marion L. Phillips, Ridgeley, W. Va.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **meningitis, H. Influenzal**

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 11, 1951, to March 15, 1951, that I last saw the deceased alive on March 15, 1951, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>Mar. 18, 1951</b>	<b>Parsons Cemetery</b>	<b>Parsons,</b>	<b>W. Va.</b>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>March 16, 1951</b>	<b>Walter R. Rantz, M.D.</b>	<b>John J. Hager</b>	<b>Cumberland, Md.</b>

202061231406

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3464



## MARYLAND STATE DEPARTMENT OF HEALTH

02161

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>None</u> TOWN <u>None</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Altoona</u> TOWN <u>Altoona</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Nancy</u> (Middle) <u>Ellen</u> (Last) <u>Platt</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>30</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/27/76</u>	9. AGE last birthday <u>75</u> yrs.	If under 1 year: Months <u>2</u> Days <u>3</u> Hours <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Allegany</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>
13. FATHER'S NAME <u>William Slater</u>		14. MOTHER'S MAIDEN NAME <u>Mary Twigg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT <u>Mrs Opal Twigg</u>		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocarditis</u>			<u>2 wks.</u>
Antecedent cause(s) (b) <u>Coronary deficiency -</u>			<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes &amp; Hypertension</u>			<u>5-10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 45 to 3-30-51, that I last saw the deceased alive on 3-30-51, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE J. J. Arnold ADDRESS Paris Park, W. Va DATE SIGNED 3-31-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/2/51</u>	NAME OF CEMETERY OR CREMATORY <u>Shepherd Springs</u>	LOCATION (City, town, or county) <u>Allegany Co</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>April 4-1951</u>	REGISTRAR'S SIGNATURE <u>Mrs. Sue C. Dineen</u>	24. FUNERAL DIRECTOR <u>W D Parker</u>	ADDRESS <u>Buckley Springs</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 6 1960  
GUTHRIE, W. V.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

Dr. Mosley  
02162

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>	
TOWN <u>Mt. Savage</u>		TOWN <u>Mt. Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MARTHA</u> (First) <u>SOPHIA</u> (Middle) <u>POLAND</u> (Last)		4. DATE OF DEATH <u>March</u> (Month) <u>6</u> (Day) <u>1951</u> (Year)	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>1-30-1874</u>
9. AGE last birthday <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hinckle</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Findlay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>John Poland, Mt. Savage, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Mitral Stenosis</u>		<u>4 years</u>
(b) <u>Moderate Hypertension</u>		<u>3 1/2 years</u>
(c) <u>Chronic Inflammation Gallbladder</u>		<u>4 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from January, 191947 to March, 191951, that I last saw the deceased alive on 3/5, 1951, and that death occurred at 5:45 m., from the causes and on the date stated above.

SIGNATURE <u>William E. Mosley M.D.</u>		ADDRESS <u>Mt. Savage, Md.</u>		DATE SIGNED <u>March 6-1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Mar. 8 '51</u>		NAME OF CEMETERY OR CREMATORY <u>St. George's Episcopal</u>	
				LOCATION (City, town, or county) <u>Mt. Savage, Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>3-7-51</u>		REGISTRAR'S SIGNATURE <u>Vernon McDermott</u>		24. FUNERAL DIRECTOR <u>J. R. Durst, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 9 1961  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02163

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write nearest town) <u>Frostburg</u> OR <u>give nearest town</u>		CITY (If outside corporate limits, write nearest town) <u>Frostburg</u> OR <u>give nearest town</u>	
TOWN <u>Frostburg</u> LENGTH OF STAY (in this place) <u>Life time</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>132 Maple St</u>		STREET ADDRESS (If rural, give location) <u>132 Maple St.</u>	
3. NAME OF DECEASED (First) <u>Anna</u> (Middle) <u>Re.</u> (Last) <u>Porcero</u>		DATE OF DEATH (Month) <u>3</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 23-1875</u>
9. AGE last birthday <u>75</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Porcero</u>		14. MOTHER'S MAIDEN NAME <u>Rachel P. Arnold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Frank J. Porcero, Frostburg, Ind.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Chr Nephritis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 year1 yrII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1950, 19....., to Mar 16, 1951, that I last saw the deceasedalive on Mar 16, 1951, and that death occurred at 11:15 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-19-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>	LOCATION (City, town, or county) <u>Frostburg</u>	(State) <u>Ind.</u>
DATE REC'D BY LOCAL REG <u>3-19-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Re Jacob</u>	24. FUNERAL DIRECTOR <u>Re Jacob</u>		ADDRESS <u>Frostburg, Ind.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 26 1951  
BUREAU OF A. I.

Within corporate limits DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02164

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>CUMBERLAND, MARYLAND</b> LENGTH OF STAY (in this place) <b>2 DAYS</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>PENNSYLVANIA</b> COUNTY <b>Bedford</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>EVERETT</b> STREET ADDRESS (If rural, give location) <b>909 N. SPRING ST.,</b>	
3. NAME OF DECEASED (Type or Print) <b>WILLIAM JOSEPH PRICE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>march 19 1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>12-29-50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE last birthday (If under 1 year) (Months) (Days) (Hours) (Min.) <b>2 20 28</b>
11. BIRTHPLACE (State or foreign country) <b>EVERETT, PA.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>	
13. FATHER'S NAME <b>SAMUEL PRICE</b>		14. MOTHER'S MAIDEN NAME <b>RUTH VIRGINIA OLESON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Memorial Hospital Cumberland, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Pneumonia</b>		<b>2 day</b>
Antecedent cause(s) (b) <b>Aspiration Stomach Contents.</b>		<b>2 days</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>See to Pyloric Stenosis</b>		<b>12 wks</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Interruption of Sleep -</b>		<b>30 min.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-17, 1951**, to **3-19 51**, that I last saw the deceased alive on **3-19 51**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **W. Elias** (Degree or title) ADDRESS **126 Queen St. Cumberland Md** DATE SIGNED **March 20, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Mar 21 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Reformed Yellow Creek</b>	LOCATION (City, town, or county) (State) <b>(Rural) Everett Pa.</b>
DATE REC'D BY LOCAL REG. <b>March 20, 1951</b>	REGISTRAR'S SIGNATURE <b>Walter R. Rontz, M.D.</b>	24. FUNERAL DIRECTOR ADDRESS <b>Shoemaker Funeral Home Everett Pa.</b>	

9VV29099699

MARGIN RESERVED FOR BINDING

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>31 Beall St.</u>		STREET ADDRESS (If rural, give location) <u>31 Beall St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIAM</u> (Middle) <u>DAVID</u> (Last) <u>REESE</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-2-1876</u>
9. AGE last birthday <u>74</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>retired minister</u>	
11. BIRTHPLACE (State or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Reese</u>		14. MOTHER'S MAIDEN NAME <u>Miriam Bowen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Richard Reese, Frostburg, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>acute congestive heart failure</u>			<u>18 hrs.</u>
Antecedent cause(s) (b) <u>Cerebral thrombosis</u>			<u>7 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>influenza</u>			<u>8 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Silicosis, severe</u>			<u>50 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1948, to 28 March, 1951, that I last saw the deceased alive on 28 March, 1951, and that death occurred at 6:02 p.m., from the causes and on the date stated above.

SIGNATURE <u>John B. Davis, M.D.</u>	DATE <u>3-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>	DATE SIGNED <u>3/29/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3-30-51</u>	NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u>	DATE SIGNED <u>3/29/51</u>
24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md.	REG. <u>3-30-51</u>	REGISTRAR'S SIGNATURE <u>Mr. Hancey &amp; Roe</u>	ADDRESS <u>J. R. Durst, Frostburg, Md.</u>	

MARGIN RESERVED FOR BINDING

M

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

009896

RECEIVED  
APR 3 1951  
BL PRAU V. B

## MARYLAND STATE DEPARTMENT OF HEALTH

02166

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

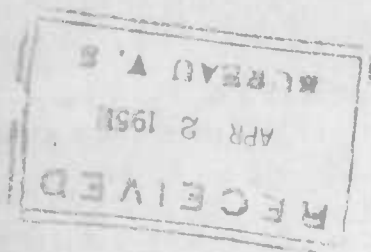
Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
TOWN <u>Brooklyn</u>		TOWN <u>Lonaconing</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>High Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>William</u> <u>a.</u> <u>Reidley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>26</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 16 - 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Coal Miner</u>	
11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Reidley</u>		14. MOTHER'S MAIDEN NAME <u>Christina Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>216-07-2783</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Reidley Lonaconing, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Lobar pneumonia - II Poss. tbc.</u>		<u>2 wks.</u>	
Antecedent cause(s) (b) <u>Pulmonary hypertension with failure as result of Lobar pneumonia.</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Acute &amp; Chronic Rheumatoid Arthritis</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>OF</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/25</u> , 19 <u>57</u> , to <u>3/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> a.m., from the causes and on the date stated above.			
SIGNATURE <u>Paul Eugene Dreyer, M.D.</u>		ADDRESS <u>Lonaconing, Md.</u>	
DATE SIGNED <u>3/26/57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>March 28 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Hills</u>		LOCATION (City, town, or county) <u>Lonaconing, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3-26-57</u>		24. FUNERAL DIRECTOR <u>M. Eichhorn</u>	
REG. <u>3-26-57</u>		ADDRESS <u>Lonaconing, Md.</u>	

658216



## MARYLAND STATE DEPARTMENT OF HEALTH

02167

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>203 W. Main St.</u>		STREET ADDRESS (If rural, give location) <u>203 W. Main St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Wilson Eugene Rizer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 30 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 6-1913</u>
9. AGE last birthday <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spinner at the Celanese Corp. of Am.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Rizer</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war of dates of service) <u>yes W.W.2</u>		16. SOCIAL SECURITY No. <u>214-07-4110</u>	
17. INFORMANT AND ADDRESS <u>wife) Edna W. Rizer</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>at once</u>
Antecedent cause(s) (b) <u>Coronary sclerosis</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE (Degree or title) <u>H.V. Deming M.D.</u>		DATE SIGNED <u>March 30-1951</u>
23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) <u>Burial</u>	DATE THEREOF <u>4-2-1951</u>	NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>
LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>		
DATE REC'D BY LOCAL REG. <u>3-31-51</u>	REGISTRAR'S SIGNATURE <u>Miss Maucy R. Roe</u>	24. FUNERAL DIRECTOR <u>J. R. Durst,</u>
		ADDRESS <u>Frostburg, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

675466

RECEIVED  
APR 3 1951  
BUREAU 7.8

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

02168

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1019 Gay St.</u>		STREET ADDRESS (If rural, give location) <u>303 Magruder St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lafayette</u>	(Middle) <u>Wilson</u>	(Last) <u>Robinson</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 10-1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Cloak Shop</u>	9. AGE last birthday <u>68</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>Thomas Robinson</u>	14. MOTHER'S MAIDEN NAME <u>Leah Jones</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>wife) Nellie Washington Robinson</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion due to</u>	<u>at once</u>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
93d (b) <u>Coronary sclerosis</u>	<u>about 3 years</u>
(c) <u>Myocardial degeneration</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE	DATE SIGNED
<u>H.V. Deming M.D.</u>	<u>March 26-1951</u>
23. BURIAL, CREMATION, OR OTHER METHOD OF DISPOSAL (Specify)	DATE THEREOF
<u>Burial</u>	<u>March 28 1951</u>
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Summer Cem.</u>	<u>Cumberland Md.</u>
24. FUNERAL DIRECTOR	ADDRESS
<u>Louis Stern Inc. Camb. Md.</u>	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE  
March 28 1951 Walter R. Gantz, M.D.

740849

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and complete cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

03110

RECEIVED  
JAN 10 1951  
U.S. DEPT. OF JUSTICE

RECEIVED  
JAN 4 1951  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02169

Reg. Dist. No. 1

1. PLACE OF DEATH- COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Little Orleans</u> OR TOWN <u>Little Orleans</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Little Orleans</u> OR TOWN <u>Little Orleans</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Raymond Lee Sheppard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 16 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 18 1981</u>
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Hancock Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Keel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Anna Tan - 406 Oldtown Rd City</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Diabetes mellitus

## INTERVAL BETWEEN ONSET AND DEATH

2 years

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.Chr. myocarditis1 year

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb 26, 1951, to Mar 16, 1951, that I last saw the deceased alive on Mar 6, 1951, and that death occurred at 12 noon m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

R. W. Trevasia, D.O. M.D. Cumberland Maryland

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 19, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hancock Md</u>	
DATE RECD BY LOCAL REG. <u>March 19, 1951</u>		REGISTRAR'S SIGNATURE <u>Mrs. Sue C. Linn</u>		24. FUNERAL DIRECTOR <u>John J. Hofer</u>		ADDRESS <u>Cumberland Md</u>	

290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 28 1963

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

02170

1. PLACE OF DEATH - COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>ALLEGANY</b> COUNTY <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>OLDTOWN, MARYLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <b>William</b> (Middle) <b>ALFRED</b> (Last) <b>SHRYOCK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 29, 1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1/10/1867</b>
9. AGE last birthday <b>84</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED S.</b>	
13. FATHER'S NAME <b>HENRY R. SHRYOCK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA HAMILTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

**26aemia**

## INTERVAL BETWEEN ONSET AND DEATH

**2 wks.**

## Antecedent cause(s)

(b)

**Arteriosclerosis**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <b>SUICIDE</b> <b>HOMICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 15, 1951, to Mar. 30, 1951, that I last saw the deceased alive on Mar. 30, 1951, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

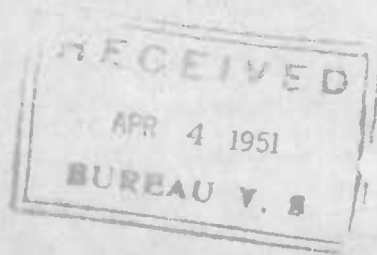
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



59

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

02171

Reg. Dist. No. 4

The correct age of the deceased must be given. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rawlings, Rural</u> LENGTH OF STAY (In this place) <u>9 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rawlings</u> TOWN <u>Rawlings</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Elmer</u> (Middle) <u>Fredrick</u> (Last) <u>Shuck</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 28-1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer, twisting Dept. Celanese Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>28</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pinto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Guy Elmer Shuck</u>		14. MOTHER'S MAIDEN NAME <u>Bertha M. Lease</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.2</u>		16. SOCIAL SECURITY No. <u>218-12-5937</u>	
17. INFORMANT AND ADDRESS <u>wife) Mrs. E.F. Shuck, Rawlings Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fractured cervical vertebrae (broken neck)</u>			<u>about 10 min.</u>
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>barn at Rawlings Allegany Md.</u>	
TIME (Month) (Day) (Year) <u>March 8/51-3 Pm.</u>		HOW DID INJURY OCCUR? <u>In barn, throwing down straw, misstep, fell through hole, fell 11 feet, hit head on concrete floor.</u>	
INJURY OF <u>March 8/51-3 Pm.</u>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED <u>March 8-1951</u>	
H. V. Deming M.D. <u>Cumberland, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-11-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Biers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Rawlings, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>March 11, 1951</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles L. George Cumberland, Md.</u>	

690466

VS. A15A

55-17



name: Dr. Weisman's letter filed 3/19/57 G131-L

Outside of  
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02172

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland</u>	
TOWN <u>near</u>		TOWN <u>near</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3, Union Grove Road</u>		STREET ADDRESS (If rural, give location) <u>Route 3, Union Grove Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>Albert</u> (Last) <u>Arthur Smouse</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 31 1856</u>
9. AGE last birthday <u>94</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>15</u> If under 24 hrs. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Route 3, Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Peter Smouse</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Neff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Albert Smouse, Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Heart Failure</u>			<u>1 hr.</u>
(b) <u>Atherosclerosis</u>			<u>39.</u>
(c) <u>Antecedent cause(s)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1948</u> , to <u>March 6, 1951</u> , that I last saw the deceased alive on <u>Feb 15, 1951</u> , and that death occurred at <u>10:05 a.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Altersman</u>		ADDRESS <u>59 Green St Cumberland 3/6/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar 8 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 8, 1951</u>		REGISTRAR'S SIGNATURE <u>Walter L. Frank, M.D.</u>	
24. FUNERAL DIRECTOR <u>William H. Kight</u>		ADDRESS <u>Cumberland, Md.</u>	

290116

RECEIVED  
MAR 18 1961  
BUREAU A. P.

## MARYLAND STATE DEPARTMENT OF HEALTH

02173

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH- COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md</i> COUNTY <i>Allegany</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Mt. Savage</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Mt. Savage</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Yellow Row</i>		STREET ADDRESS (If rural, give location) <i>Yellow Row</i>	
3. NAME OF DECEASED (Type or Print) <i>Catherine</i> (First) (Middle) (Last) <i>Snyder</i>		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>18</i> (Year) <i>1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>July 10, 1864</i>
9. AGE last birthday <i>86</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Wellersburg, Pa.</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John A. Snyder</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hostetler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Frank Snyder, Mt. Savage, Md.</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

*Mitral Stenosis*INTERVAL BETWEEN ONSET AND DEATH  
*6 months*

## Antecedent cause(s)

(b)

*Moderate Hypertension & Arteriosclerosis**54 years*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

*Chronic Bronchial Asthma**5 years - longer*

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY  
m.INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *January 1946* to *March 16<sup>th</sup> 51*, that I last saw the deceasedalive on *March 16, 1951*, and that death occurred at *4:15 p.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*William E. Mosely**Mt. Savage, Md.**March 19-1951*

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*March 20, 1951**Veronica McDermott**John J. Hoffa, Cumberland, Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 26 1961  
LIBRARY A.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02174

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hosp.</u>		STREET ADDRESS (If rural, give location) <u>222 Glenn St.,</u>	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>HENRY</u> (Last) <u>SPENCER</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Mar. 18,</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 15, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Bedford Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Nellie Spencer Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cardiac failure - pulmonary edema</u>		<u>3 days</u>	
Antecedent cause(s) (b) <u>Old rheumatic fever, mitral valve disease</u>		<u>50 years</u>	
(c) <u>Jamieson due to Cholelithiasis</u>		<u>1 week</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bilateral incarcerated inguinal hernia</u>		<u>2 days</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 23 Jan, 1951, to 18 March, 1951, that I last saw the deceased alive on 18 March, 1951, and that death occurred at 54 Green St Cumberland Md m., from the causes and on the date stated above.

SIGNATURE Harold G. Meisner MD ADDRESS 54 Green St Cumberland Md DATE SIGNED 20 March 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-21-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Robinsonville Cem.</u>	LOCATION (City, town, or county) (State) <u>Robinsonville, Penna.</u>
DATE REC'D BY LOCAL REG. <u>March 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Hark, M.D.</u>	24. FUNERAL DIRECTOR <u>Charles L. George</u>	ADDRESS <u>Cumberland, Md.</u>

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631

RECEIVED  
MAR 27 1951  
BUREAU Y. B.

DR. WEISMAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02175

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <b>ALLEGANY</b> STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MARYLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		STREET ADDRESS (If rural, give location) <b>BOX 81, R.F.D. 1,</b>	
3. NAME OF DECEASED (First) <b>BESSIE</b> (Middle) <b>MAY</b> (Last) <b>STARK</b>		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>1</b> (Year) <b>1951</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>FEB 7, 1877</b> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE REUSCHLEIN</b>		14. MOTHER'S MAIDEN NAME <b>SNYDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

(a)

**acute left ventricular failure**

INTERVAL BETWEEN ONSET AND DEATH

**6 hours**

Antecedent cause(s)

(b)

**Myocardial Infarction****6 hours**

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

**Coronary Insufficiency****6 years**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**Arteriosclerotic Heart Disease****6 yrs**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
**INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar 1, 1951**, to **Mar 1, 1951**, that I last saw the deceasedalive on **Mar 1, 1951**, and that death occurred at **1:40 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Harville G. Weisman MD****59 Green St****Cumberland****3/2/51**

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

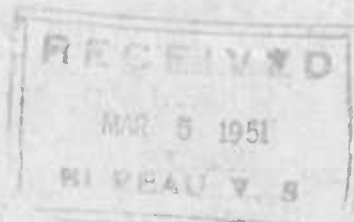
## 24. FUNERAL DIRECTOR

## ADDRESS

**March 3, 1951****Walter R. Bantz, MD.****Louis Stein, Inc****Cumberland, Md**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of  
City limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02176

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> TOWN <u>LaVale</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>48 LaVale Blvd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Allegheny</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> TOWN <u>LaVale</u> STREET ADDRESS (If rural, give location) <u>48 LaVale Blvd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ann Stevens</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 2 1858</u>
9. AGE last birthday <u>92</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Daniel Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth - Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>James Stevens, LaVale, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause  
107 Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) branch occlusion oia  
(b) old age, arteriosclerosis  
(c)

INTERVAL BETWEEN ONSET AND DEATH

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1942, to 3/28, 1951, that I last saw the deceased alive on 3/27, 1951, and that death occurred at 12 a. m., from the causes and on the date stated above.

SIGNATURE Elizabeth Stevens (Degree or title) ADDRESS 14 D. 55 Greene St. DATE SIGNED 3/30/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-31-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>	LOCATION (City, town, or county) <u>Frostburg</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>March 30, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter K. Hank</u>	24. FUNERAL DIRECTOR <u>Jacob Hafer</u> ADDRESS <u>Frostburg, Md.</u>		

MARGIN RESERVED FOR BINDING

I

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 4 1951

BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 2</u>		STREET ADDRESS (If rural, give location) <u>Rt. 2</u>	
3. NAME OF DECEASED (First) <u>ELMER</u> (Middle) <u>LEROY</u> (Last) <u>STOTT</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>12-30-1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS or INDUSTRY	9. AGE last birthday <u>2</u> yrs. <u>25</u> Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min.
13. FATHER'S NAME <u>Elmer Stott</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Elmer Stott, Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonia, lobar, bilateral</u>			<u>36 hrs</u>
Antecedent cause(s) (b) <u>Acute upper respiratory infection</u>			<u>72 hrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>108</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 March, 1951, to 26 March, 1951, that I last saw the deceased alive on 26 March, 1951, and that death occurred at 4:00 p.m. from the causes and on the date stated above.

SIGNATURE John B. Davis, M.D. ADDRESS Frostburg Md. DATE SIGNED 3/27/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3-28-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Percy Cemetery</u>	LOCATION (City, town, or county) <u>Frostburg, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>3-28-51</u>	REGISTRAR'S SIGNATURE <u>Wm. Hancey V. Fox</u>	24. FUNERAL DIRECTOR <u>J. R. Durst,</u>	ADDRESS <u>Frostburg, Md.</u>

204 300285408

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 2 1951  
STRAU A. S.

Within corporate limits

DR. DURETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02178

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, ME.</b>		STREET ADDRESS (If rural, give location) <b>231 BEDFORD STREET</b>	
3. NAME OF DECEASED (First) <b>EMILY</b> (Middle) <b>B.</b> (Last) <b>TWIGG</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>MARCH 7 1951</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, <b>DIVORCED</b> (Specify)	8. DATE OF BIRTH <b>MAY 2, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept store</b>	9. AGE last birthday <b>57</b> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>MICHAEL TWIGG</b>		14. MOTHER'S MAIDEN NAME <b>Kifer, AMANDA</b>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>220-07-6246</b>	
17. INFORMANT AND ADDRESS <b>Mrs Denver Kimple</b>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
2041 Immediate cause (a) <b>Acute myelogenous leukemia</b>		<b>P</b>
74a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT (Specify) <b>SUICIDE</b> PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b> (CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar 6, 1951**, to **Mar 7, 1951**, that I last saw the deceased alive on **Mar 7, 1951**, and that death occurred at **4:00 P.** m., from the causes and on the date stated above.

SIGNATURE **Clay E. Smith M.D.** ADDRESS **Cumberland** DATE SIGNED **3/8/51**

23. BURIAL, CREMATION OR REMOVAL (Specify) **Burial** DATE THEREOF **March 10-1951** NAME OF CEMETERY OR CREMATORY **Bethel Cemetery** LOCATION (City, town, or county) (State) **Bedford Valley Pa.**

DATE REC'D BY LOCAL REG. **March 9, 1951** REGISTRAR'S SIGNATURE **Walter L. Rantz M.D.** 24. FUNERAL DIRECTOR **Louis Stein Inc.** ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

490646

4711.

RECEIVED  
MAR 13 1961  
ST. LOUIS, MO.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02179

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 2 .....

1. PLACE OF DEATH- COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Flintstone</b>		LENGTH OF STAY (in this place) <b>8 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Flintstone</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<b>Lorenzo</b>		<b>Cecil</b>		<b>Twigg</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday	
<b>Male</b>	<b>White</b>	<b>W</b>		<b>4/11/1871</b>		<b>79 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles A. Twigg</b>				14. MOTHER'S MAIDEN NAME <b>Susan ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT AND ADDRESS <b>Dayton Twigg, Cumberland, Md.</b>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

420.1 Immediate cause	(a) <b>Coronary Thrombosis</b>	<b>sudden</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <b>Arteriosclerotic cardio vascular disease</b>	<b>5 years</b>
(c)		

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 15, 1951**, to **Mar. 27, 1951**, that I last saw the deceasedalive on **Mar. 10, 1951**, and that death occurred at **1:45 p.m.**, from the causes and on the date stated above.SIGNATURE **Clay E. Smith** (Degree or title) ADDRESS **M.D. Cumberland, Md.** DATE SIGNED **3/27/51**

23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>3/29/51</b>	NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	LOCATION (City, town, or county) <b>Oldtown, Md.</b>	(State)
DATE REC'D BY LOCAL REG <b>3/28/51</b>	REGISTRAR'S SIGNATURE <b>Mina L. Bender</b>	24. FUNERAL DIRECTOR <b>William H. Right</b>	ADDRESS <b>Cumberland Md</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290116

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02180

Reg. Dist. No. 9

Evidence for change  
in #9 shown on:

FILM No. G 131 MAR 19 1951 CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>163 E. Main St.</u>		STREET ADDRESS (If rural, give location) <u>163 E. Main St. Frostburg, Md.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Saveria</u> <u>Via</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3/12/51</u> 19 <u>51</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/27/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Celico Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phillip Sicoli</u>		14. MOTHER'S MAIDEN NAME <u>Carmelia Scanza</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Frank Via 163 E. Main St. Frostburg</u>			

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause	(a) <u>Acute Cardiac Dilatation</u>	INTERVAL BETWEEN ONSET AND DEATH <u>7n sleep</u>
260x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertension</u>	<u>24 years</u>
61	(c) <u>Diabetes</u>	<u>several years</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1940, 1951, to Mar 12, 1951, that I last saw the deceased alive on Mar 11, 1951, and that death occurred at 5:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Michael's Cem.</u>	LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-13-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u>	24. FUNERAL DIRECTOR <u>James F. Scarpelli</u>	ADDRESS <u>Cumberland, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02181

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>WEST VIRGINIA</b> COUNTY <b>MINERAL</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>CUMBERLAND</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>RIDGLEY</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>MEMORIAL HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>ROUTE #1</b>	
3. NAME OF DECEASED (Type or Print) <b>Frank</b> (First) <b>BABY BOY</b> (Middle) <b>Dean</b> (Last) <b>WAGNER</b>		4. DATE OF DEATH (Month) <b>MARCH</b> (Day) <b>1</b> (Year) <b>1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, <b>SINGLE</b> (Specify)	8. DATE OF BIRTH <b>FEB. 28, 1951</b>
9. AGE last birthday <b>1</b> yrs. If under 1 year Months <b>1</b> Days <b>1</b> If under 24 hrs. Hours <b>1</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WAGNER, JOHN F.</b>		14. MOTHER'S MAIDEN NAME <b>NIEMANN, ELIZABETH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Memorial Hospital</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 days

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19..... and that death occurred at..... m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 2, 1951

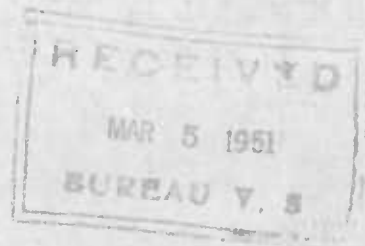
Walter K. Hantz, M.D.

Memorial Hosp, Cumberland, Md.

222291271301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02182 9

1. PLACE OF DEATH- COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
TOWN <b>Frostburg</b>		TOWN <b>Frostburg</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>30 Washington St.</b>		STREET ADDRESS (If rural, give location) <b>30 Washington St.</b>	
3. NAME OF DECEASED (Type or Print) <b>HERMAN</b> (First) <b>WAGNER</b> (Last)		4. DATE OF DEATH <b>March 12, 1951</b> (Month) (Day) (Year)	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>4-26-1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese plant</b>	11. BIRTHPLACE (State or foreign country) <b>Elizabeth, Penna.</b>
13. FATHER'S NAME <b>Adam Wagner</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Lapp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>241-07-3557</b>	17. INFORMANT AND ADDRESS <b>Mrs. James Elias, Frostburg, Md.</b>

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Coronary Occlusion</b>			<b>Sudden</b>
Antecedent cause(s) (b) <b>Chronic Myocarditis</b>			<b>4 years</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>93d</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1947**, 19....., to **March 12, 1951**, that I last saw the deceased alive on **Jan 29, 1951**, and that death occurred at **9:15 A.M.** m., from the causes and on the date stated above.

SIGNATURE <b>William Lane MD</b>		ADDRESS <b>Frostburg Md</b>		DATE SIGNED <b>Mar 14 1951</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>3-15-1951</b>	NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	LOCATION (City, town, or county) <b>Frostburg, Md.</b>	(State)
DATE REC'D BY LOCAL REG. <b>3-15-51</b>	REGISTRAR'S SIGNATURE <b>Mrs. Nancy X. Roe</b>	24. FUNERAL DIRECTOR <b>J. R. Durst,</b>	ADDRESS <b>Frostburg, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

770466

RECEIVED  
MAR 20 1951  
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles Street, Baltimore  
CERTIFICATE OF DEATH

02183  
4

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegany Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Harvey William Whitacre</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 26, 1888</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler house fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Little Cacapon, W. Va</u>	
13. FATHER'S NAME <u>Jacob W. Whitacre</u>		14. MOTHER'S MAIDEN NAME <u>Emily Seaton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Bessie Whitacre, Mt. Savage, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>R. Cerebral Hemorrhage</u>	<u>3 wks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arterio Sclerosis</u>	<u>2 or 3 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Left Hemiplegia</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1950, to March 14 1951, that I last saw the deceased alive on March 13, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>J. H. M. Murray M.D.</u>	(Degree or title)	ADDRESS <u>Cumberland, Md.</u>	DATE SIGNED <u>March 14/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Savage Methodist Cemetery</u>	LOCATION (City, town, or county) (State) <u>Mt. Savage Md.</u>
DATE REC'D BY LOCAL REG. <u>March 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Brant, M.D.</u>	24. FUNERAL DIRECTOR <u>John J. Hoyle</u>	ADDRESS <u>Cumberland, Md.</u>

680869

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 20 1950  
BUREAU 7. 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02184

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Ind.</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Front St.</u>		STREET ADDRESS (If rural, give location) <u>15 Front St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lora</u> (First) <u>Willson</u> (Middle) <u>Willson</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Apr 12 - 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg, Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. H. Evans</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Farrady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Verner Carpenter, Frostburg, Ind.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Carcinomatosis

## INTERVAL BETWEEN ONSET AND DEATH

3 mo

## Antecedent cause(s)

(b)

Carcinoma of Rectum6 years

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1946, 1951, to Nov 10, 1951, that I last saw the deceasedalive on Mar 10, 1951, and that death occurred at 11:15 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

<u>3-13-51</u>	<u>Mrs. Nancy A. Roe</u>	<u>Jacob Haper, Frostburg, Ind.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

02185

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>W.Va.</u> COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u> <u>Keyser</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Route #2 Box 97</u>	
3. NAME OF DECEASED (First) <u>Jounetia</u> (Middle) <u>Evelyn</u> (Last) <u>Wilson</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>May 6-1926</u>
9. AGE last birthday <u>24</u> yrs.		10. AGE last birthday If under 1 year Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leslie Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Anna Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Hospital records.</u>	
17. INFORMANT AND ADDRESS <u>Hospital records.</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Intrathoracic hemorrhage due to</u>		<u>19 hrs.</u>
(b) Antecedent cause(s) <u>fractured ribs, right side of chest.</u>		
(c) <u>Cutaneous emphysema, right arm &amp; chest.</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>rural</u> INJURY <u>Highway</u>	2 miles north of Short Gap, W.Va. Old Furnace Rd. Route 28 (Mineral Co.) HOW DID INJURY OCCUR? <u>Auto. left road, went down an embankment &amp; hit a tree.</u>
TIME (Month) (Day) (Year) (Hour) <u>March 18/51</u> A. M.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md.

March 19-1951

23. BURIAL, CREMATION BY (Specify) <u>Burial</u>	DATE THEREOF <u>3-21-51</u>	NAME OF CEMETERY OR CREMATORY <u>Zion Memorial</u>	LOCATION (City, town, or county) <u>Cumberland, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Walter R. Rantz, M.D.</u>	24. FUNERAL DIRECTOR <u>Charles L. George</u>	ADDRESS <u>Cumberland, Md</u>	

MARGIN RESERVED FOR BINDING

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